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A COMPARISON OF THE RECOGNITION OF PSYCHOPATHOLOGY
AND ATTITUDES TOWARDS MENTAL ILLNESS BETWEEN
PARAPROFESSIONALS AND PROFESSIONALS IN
COUNSELING AGENCIES

A Dissertation Presented

By

MIRIAM F. HIRSCH

Submitted to the Graduate School of the
University of Massachusetts in
partial fulfillment of the requirements for the degree of

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Major Subject: Counseling and Guidance


A COMPARISON OF THE RECOGNITION OF PSYCHOPATHOLOGY
AND ATTITUDES TOWARDS MENTAL ILLNESS BETWEEN
PARAPROFESSIONALS AND PROFESSIONALS IN
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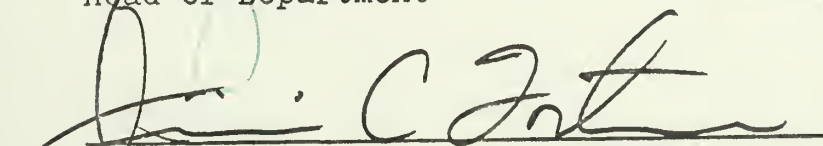
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Miriam F. Hirsch

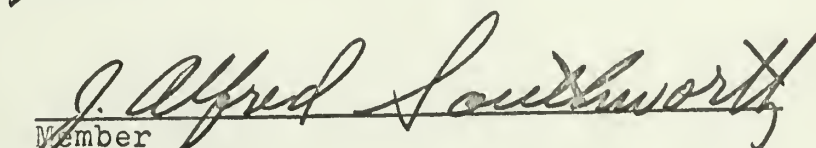
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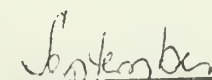

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C H A P T E R I

INTRODUCTION

The use of paraprofessionals is not a new phenomenon. Paraprofessionals have been involved in mental health teams within the military since World War II. Their main functions consisted of "assisting in relieving manpower shortages, optimizing the function of professionals, adding new competence and directions, and providing stimulation as well as added resources for the military" (Nolan and Clarke, 1970, p. 74). It is only fairly recently that paraprofessionals as mental health counselors began to be used in civilian hospitals and clinics.

There is an increase in our society in the training and use of the paraprofessional as a therapeutic agent. One reason for this increase has been the result of findings which indicate that traditional methods of therapy have not been effective with the disadvantaged (Hollingshead and Redlich, 1958). This, plus the shortage of manpower, coupled with increasing demands for service pleads for a review of our approach in the helping professions for the use of new manpower resources (Albee, 1959). One of these new resources is the paraprofessional.

The majority of psychiatrists practice in urban areas in larger numbers than the relative concentration of population. According to Guerney (1969), more than half of

the psychiatrists who are trained under grants by NIMH are involved in private practice. Social work is presently facing a crucial period of expanding services and an ever-increasing manpower shortage, as the number of graduates from social work schools continues to fall short of the number needed. In 1966 it was estimated that there were 10,000 social workers needed for programs in the department of HEW alone.

There is an ever-increasing need for mental health counselors in our society. The tremendous mobility rate, increasing alienation and anomie, lack of individual power with its effects of increased personal maladjustment and family instability, have led to greater demands for services from agencies whose function is the giving of human services. These agencies have been unable to meet the demands because of lack of money but moreover because of lack of staff.

These factors in addition to the large numbers of unused resources (the poor) led the Howard University Institute for Youth Studies (formerly, the Center for Youth and Community Studies), to develop a model for the training of nonprofessionals in the human service fields. During 1964 to 1967 under grants from the Federal government, the New Careers Program developed. About 150,000 nonprofessional positions resulted from poverty and related legislation (Riessman and Pearl, 1965).

The paraprofessional usually comes from the lower socio-economic class. Class status is considered a great influence on life styles, attitudes and perceptions. Particularly attitudes towards mental illness seem to be influenced by class status.

All major public opinion surveys indicate that a large part of the population, and lower socio-economic groups in particular, still equate mental illness with only the severest forms of disorder--those marked by loss of control, loss of reason, and inappropriate and violent behavior (Star). Individuals in these groups often delay efforts to secure treatment until their illness conforms to this concept (Riessman, 1965, p. 798).

How does the paraprofessional's perception of maladaptive behavior affect his ability to counsel and refer? Meyers and Bean (1968) indicate that the lower socio-economic class defined mental illness as craziness or insanity and expressed fear of institutionalization. The Meyers and Bean study of class differences in mental illness confirmed that institutionalization was more of a fact than a myth. In a ten-year follow-up study of Hollingshead and Redlich's New Haven study, ninety-three per cent of people who were in state hospitals at the time were still institutionalized. In comparison, almost all of the patients from the middle and upper income group had been released.

There is historical and anthropological evidence that culture has an effect on perception (Blake and Ramsey, 1951). Malinowski has indicated that recognition or resemblance of facial features is affected by culture. The

Trobriand Islanders never see facial resemblances among maternal relatives but note and sometimes exaggerate resemblances among paternal kinsmen. Culture influences the responses to the questions on the Rorschach test as well as the interpretations. If differences in social class status imply differences in values, child rearing, family patterns, and perception, and if all of these are cultural traits, then is not social class an important determinate of behavior? Members of different social classes experience different conditions of life and therefore perceive the world differently. These different perceptions result in different behavior expectations (Kohn, 1963).

Social class is one of the factors which is related to mental health. Studies indicate that there is a positive relationship between social class and attitudes towards all aspects of medical care. Lower-class individuals are often remiss concerning their physical and mental health,

. . . because they lack understanding of the complexities of scientific diagnosis and therapy. Since their educational level precludes a scientific interpretation of disease causation, less sophisticated or uneducated people prefer to depend on folk concepts and folk therapy (Mahan, 1966, p. 14).

They are afraid of mental illness and express hostility towards therapists.

The psychiatric problems of the poor are usually involved with other problems.

Since mental health services for the poor people in this country are markedly inferior on the whole, both in quantity and quality, corrections of these injustices becomes a specific top priority in our field (Bernard, 1965, p. 254).

There need to be changes in the type of treatment the poor receive which would take into account the socio-cultural and value orientation differences between therapists and patients which create problems in the therapeutic situation. The use of the paraprofessional helps to eliminate that difficulty. However, since paraprofessionals come from a low socio-economic class, it can be assumed that their perceptions and attitudes are influenced by their class status and therefore the question arises as to whether they can identify behavior as maladaptive as competently as does the professional who is influenced by his middle- or upper-class status?

Statement of the Problem

The purpose of this study is two-fold:

1. To determine the difference between the median response levels on a questionnaire developed by Star of counseling paraprofessionals and counseling professionals in their ability to identify maladaptive behavior. (The behaviors to be focused upon are those patterns which are defined as psychogenic in the 1968 Diagnostic and Statistical Manual of the American Psychiatric Association. Behaviors of paramount interest are those which are

considered to be maladaptive and are hypothesized to be harmful to those displaying them or to others.)

2. To determine the expressed social distance from ex-mental patients of the two groups, paraprofessional and professional. The measurement of social distance was to be made using the Cummings Social Distance Scale as to their significance.

The research question of major interest then is to determine if counseling paraprofessionals who by definition come from the lower socio-economic level of society and who normally have less education than the professionals, recognize mental illness on the same level of perception and have attitudes towards mental illness similar to those expressed by the professionals.

Definitions

Counseling paraprofessional. An indigenous person who has had a high school education or less and who has been exposed to a minimum of a two-week training program in counseling.

Counseling nonprofessional. A person who has had some college or graduated from college but who does not have a Master's Degree in Counseling Social Work, or Clinical Psychology.

Counseling professional. A person with a minimum of a Master's Degree in Counseling Social Work or Clinical Psychology.

Perception. "The act or faculty of apprehending by means of the senses or of the mind" (Random House Dictionary, 1966, p. 1069).

Maladaptive behavior. As used in this study it means behaviors which show deviations from the psychiatric norms and defined as psychogenic by the 1968 Diagnostic and Statistical Manual of the American Psychiatric Association.

Attitude. "A state of readiness, a tendency to act or react in a certain manner when confronted with certain stimuli" (Oppenheim, 1966, p. 105).

Significance of the Problem

There are an increasing number of paraprofessionals joining professionals from psychiatry and social work. A study made for the National Institute of Mental Health and published by Sobey (1970) indicates that of 185 projects sponsored by the Institute between 1960 and 1967, more than 10,000 non-professionals were used. This was six times the number of professionals and the non-professionals had put in eight times the number of man hours as the professionals. In 109 of these projects the non-professionals performed counseling functions (New York Times, June 1, 1970). In many of the urban areas, what is labeled non-professional

is really an individual from the community who is given specialized training (the paraprofessional).

The use of the indigenous paraprofessional is an innovative approach to counseling the disadvantaged and contributes to the alleviation of the manpower shortage in the helping professions. It has required the professional to define his role in order to determine which of the many tasks he performs could best be performed by a non-professional. The use of paraprofessionals results in the provision of new careers for the poor. Thus, in addition to helping the manpower needs of the counseling profession, the poor are trained for and provided with jobs which in turn affect their life style and the cycle of poverty (Pearl and Riessman, 1965).

The use of the paraprofessional necessitates a clear definition of the counselor role, the establishment of clear-cut goals in therapy, and knowledge of the strengths and limitations of people from lower socio-economic status who are placed in counseling roles. The results of this present study could have implications for the training and use of paraprofessionals. If, indeed, the hypotheses are supported then the paraprofessional would not perceive behavior as maladaptive as would the professional and would have a greater social distance from ex-mental patients than the professional. If he does not perceive the behavior as malfunctioning, then the paraprofessional will not feel

the need to refer for treatment or be able to work with people on a counseling basis whose behavior he does not identify as symptomatic of emotional difficulty.

What are the factors which make a paraprofessional effective in a therapeutic relationship? The paraprofessional is informal, neighborly and earthy (Pearl and Riessman, 1965). He is the product of the culture of the area and therefore it is hypothesized that he can serve as a bridge between the agency and the community. He speaks the same language and therefore may be more capable of communicating with the client.

Moreover, since patients and nonprofessionals come from social and economic backgrounds which are similar in many respects, there can be opportunity to identify factors responsible for successful functioning in the deprived community, and to use this information in treating those who have shown lack of success, whether by the development of psychoses, delinquency, or the more usual apathy, self-hate, and despair (Christmas, 1969, p. 166).

The indigenous nonprofessional has value as a role model for the client; a "significant other." But the question may be asked as to whether the paraprofessional is as skilled as the professional in recognizing certain patterns of behavior as being symptomatic of mental illness. Do paraprofessionals express more social distance toward ex-mental patients than do professionals? This study will attempt, in a limited way, to contribute to the sparse knowledge now available on the differences between the

paraprofessional and the professional in their perception of behavior.

During the past fifteen years there have been several studies on perception and attitudes of laymen (Star, 1955; The Cummings, 1957; Lemkau and Crocetti, 1962), leaders in the community (Bentz and Edgerton, 1970; Dohrenwend and Chin-Shong, 1967), and teachers (Bentz, Edgerton, and Miller, 1969) towards mental illness. There has not, however, been reported in the literature studies which deal with the perceptions of the counseling paraprofessional and particularly the comparison of the paraprofessionals with the professionals in the identification of behavior as symptomatic of mental illness. This study will attempt to add a small piece of knowledge to this area.

There is a great deal of literature in the journals relating to social class and mental illness in terms of symptomology, treatment, hospitalization and degree of social distance from ex-mental patients (Brill and Storow, 1960; Fletcher, 1968; Hollingshead and Redlich, 1958; Dohrenwend and Chin-Shong, 1967; Freeman and Simmons, 1963). Social class has also been related to tolerance of deviance (Dohrenwend and Chin-Shong, 1967) and perceptions of and attitudes towards mental illness (Star, 1955; Dohrenwend, 1967). This study raises the question as to whether paraprofessionals with their lower socio-economic class orientation are less able to identify

abnormal behavior than professionals who are middle class? The answers to the questions raised may have implications for the use and training of counseling paraprofessionals.

Hypotheses

1. The counseling paraprofessional and the counseling professional will differ in their identification of mental illness as measured by the attitude questionnaire developed by Star (1950) for the National Opinion Research Center of Chicago in 1955. Counseling professionals will identify a significantly larger number of people (at the .05 level of significance) as mentally ill than the counseling paraprofessional on the five vignettes developed by Star.

2. The counseling paraprofessional and the counseling professional will differ significantly (at the .05 level of significance) in their degree of expressed social distance from an ex-mental patient as measured by the social distance scale used by the Cummings.

Limitations of the Study

Because there will be difficulty in sampling due to the small number of accessible paraprofessionals in the greater Springfield area of Massachusetts, we will have to use the available population. We therefore cannot conclude that the sample is truly representative of paraprofessionals

throughout the country. The results of this study will therefore have limited generalizability.

This study will also be limited by the fact that experience in the field will not be comparable for the two groups. In addition, the sample will be limited to those who agree to participate.

Summary

Demands for human services continue to increase as the training of personnel needed to meet these demands continues to lag behind. The use of the paraprofessional as a counseling agent is one of the newer approaches to meeting the increased demands for counseling. The paraprofessional is usually recruited from the area being served and by definition is a member of the lower socioeconomic group. The purpose of this research is to compare the paraprofessional and the professional to see whether because of different class identification, they may differ in their ability to identify behavior defined as maladaptive by the American Psychiatric Association, and also whether they differ in their expressed social distance from ex-mental patients.

The following chapter will review the literature on the disadvantaged focusing on the influence of class status as it affects counseling behavior. Research on psychiatric problems and the influence of social class

will also be reported. Paraprofessionals are mainly employed to work with people who live in their area and who need counseling help. Since paraprofessionals are "one of the people," it is important to understand the potential influence lower socio-economic group status has on them and how it might influence them in their counseling tasks.

C H A P T E R I I

REVIEW OF LITERATURE

Sobey in the introduction to her book, The Non-professional Revolution in Mental Health, states that a crisis situation exists in this country.

An estimated nineteen million Americans suffer from mental illness. Five million alcoholics need treatment. Accurate figures on drug addiction are difficult to obtain, but reports from high schools and colleges indicate a steady increase in the use of drugs among the youth of the nation. The fear of violent crimes against public figures and the average citizen is now extreme. Youth account for a consistently increasing percentage of crime, greater even than their increasing percentage of the population. Many of the aged, living longer than their forbears, appear desolate and without a sense of human worth. For many Americans, the problems of mental illness are compounded by poverty, social inequality, and a grim, urban environment (p. 1).

In spite of the fact that poverty creates added burdens to problems, the availability of services to the poor and the use of these services is minimal. Definitions of mental health are class oriented and the model of mental health is highly correlated with the prototype of middle-class (Gursslin et al., 1959). This creates difficulties for the disadvantaged since they are evaluated according to middle-class standards and are given the type of treatment they cannot use well since their orientation is different from that of the therapist.

Members of different social classes by virtue of enjoying (or suffering) different conditions of life,

come to see the world differently--to develop different concepts of reality, different aspirations and hopes and fears, different conceptions of the desirable (Kohn, 1963).

The paraprofessional generally comes from the lower class. Because of this, he is of help to the disadvantaged since he shares with them their perceptions of reality. Who are the disadvantaged and why are traditional therapeutic methods ineffective with them is a vital question. Understanding this, one also develops a better understanding of the paraprofessional.

In the literature, the culturally disadvantaged, the lower class, or the poor are terms which are used interchangeably. These groups are described broadly in terms of: (1) class (characteristics involving economic role or income); and, (2) culture or status criteria which involves description of the style of life (Gans, 1964).

Amos in his book Counseling the Disadvantaged Youth (1968) depicts the disadvantaged as "those who are a product of a culture that has not provided them with the motivations, opportunities, experiences, and relationships that will enhance their chances for competing successfully with their fellow citizens in all phases of life" (p. 14). This is a broad definition which encompasses those who are emotionally deprived or who are deficient in education, and deficient in experiences which facilitate their participation in the mainstream.

Economically, according to the Federal government, the disadvantaged would include those people whose level of income is lower than \$3600 for an urban family of four. However, stability of income as well as source of income would affect the class definition of the disadvantaged. Hollingshead's index-occupation, education, place of residence reflects the class criteria of definition (Hollingshead and Redlich, 1958).

The style of life criteria in defining the disadvantaged incorporates attitudes and behaviors in family life as well as consumer behavior. It involves attention to the culture or life style of the individual.

The concept of a culture of poverty was coined by Oscar Lewis in 1961 in his book The Children of Sanchez in which he stated that:

The term culture, implies, essentially, a design for living. Some of the social and psychological characteristics include living in crowded quarters, a lack of privacy, gregariousness, a high incidence of alcoholism, frequent resort to violence in the settlement of quarrels, frequent use of physical violence in the training of children, wife beating, early initiation into sex, free unions or consensual marriages, a relatively high incidence of the abandonment of mothers and children, a trend toward mother-centered families and a much greater knowledge of maternal relatives, the predominance of the nuclear family, a strong disposition to authoritarianism, and a great emphasis on family solidarity--an ideal only rarely achieved. Other traits include a strong present time orientation with relatively little ability to defer gratification and fatalism based upon the realities of their difficult life situation, a belief in male superiority which reaches its crystallization in machismo or the cult of masculinity, a corresponding martyr complex

among women, and finally a high tolerance for psychological pathology of all sorts (pp. xxvi, xxvii).

He views all of these traits as attempts by a group of people to adjust to and survive in a very difficult situation and he states that this culture transcends national boundaries. Oscar Lewis defines the disadvantaged in terms of the style of life criterion.

Another advocate of the style of life definition of the disadvantaged is S. M. Miller (1964). He divides the disadvantaged into four categories. The first consists of the stable poor who are characterized by their economic and familial stability and who are made up of people from farm and rural non-farm areas and the aged. The strained comprise those who have economic security but who are unstable familially. "The Copers" are those poor who are economically insecure but who have a family cohesiveness which helps them manage to keep themselves intact. "The Unstable" is the group that is often called "the lower class," and is characterized by both financial and familial instability. The aged, the physically handicapped and the partially urbanized, newly migrant Negro comprise this group. Within this group are those who are considered chronically in difficulty (the "hard-core"). "'Lower class' life is crisis-life, constantly trying to make-do with string where rope is needed. Anything can break the string" (Miller, 1964, p. 147). Here we find the unskilled,

the irregular workers, broken as well as large-sized families, the aged, the mentally disturbed, and the physically handicapped.

If we accept the life style criterion in understanding the disadvantaged, we can then accept the concept that basic cultural differences do exist between them and the middle- and upper-class components of society.

Because different social classes experience different conditions in life their perceptions of the world are different as well as their conceptions of reality. This results in parent-child relationships containing different hopes, fears and desires for their children (Chilman, 1966).

Child-rearing and family life patterns of poor families have been characterized by:

1. Limited freedom for exploration (partly imposed by crowded and dangerous aspects of environment).
2. Constricted lives led by parents: fear and distrust of the unknown.
3. Fatalistic, apathetic attitudes.
4. Tendency for abrupt transition to independence: parents tend to lose control of children at an early age.
5. Tendency to educational-occupational failure: reliance on personal versus skill attributes of vocational success.
6. Magical, rigid thinking.
7. Little verbal communication, especially of an interactive, conceptual, flexible kind.
8. Academic achievement not highly valued.
9. Authoritarian child-rearing attitudes.
10. Fear and distrust of the school system.
11. Pragmatic, concrete values (Chilman, p. 43).

Riessman contends that the deprived child is constantly bombarded by stimuli (noise in the tenement, sibling quarrels, etc.) but that he does not realize his creative potential because of his verbal inadequacies. These children make use of a good number of words fairly precisely, but these words are not the kind of words used in school (Eels and Havighurst, 1951). Disadvantaged children are more comfortable in the use of "public language" (short, simple sentences) but "formal language" is not their forte (Bernstein, 1959). Martin Deutsch of the Institute for Development Studies, Department of Psychiatry of the New York Medical College found:

1. Deprived children seem to be poor in the use of verbs, but much better with descriptive adjectives.
2. Deprived children seem to understand more language than they speak and their "receptive" linguistic ability is much better than their "expressive" language.

These characteristics have tremendous implications for counseling the disadvantaged.

The many attempts to define the disadvantaged are indicative of a lack of a clarity in understanding who the disadvantaged really are. One needs to be concerned with more than how much an individual earns since income alone does not determine the individual's adjustment and ability to succeed on society's terms. The disadvantaged may be defined as those people, who because of income and/or race, are part of a life style or culture which impedes

them from developing those skills necessary for entrance into and success in the mainstream of society. These skills would include motivation for upward mobility, education, verbal facility, a work-oriented plan, etc.

Counseling Defined

Defining counseling and distinguishing it from psychotherapy is as difficult as attempting to define the disadvantaged. The definitions of either counseling or psychotherapy seem to be acceptable to both disciplines. Both processes are concerned with a special relationship involving an individual who requests help and a person who has had the training to provide such help (Patterson, 1966). The Committee on Definition, Division of Counseling Psychology of the American Psychological Association has defined the objective of counseling as "to help individuals toward overcoming obstacles to their personal growth, wherever these may be encountered, and toward achieving optimum development of their personal resources" (1956, p. 282). These objectives are also those of psychotherapy. Hahn and McLean (1951) have defined counseling as the process of helping people who are unable to cope with their personal problems. They add that the counselor is a professional, whose training and experiences have qualified him to aid others to reach solutions to various types of

personal difficulties. In this paper, counseling, therapy, and casework will be used interchangeably.

Counseling the disadvantaged and helping them with their personal growth must take into consideration and involve concern with their environment because it is this environment which has been instrumental in creating difficulty and in reinforcing the problem. It is also this environment which creates difficulties in applying traditional counseling methods in an effective manner.

Traditional Counseling Approaches and the Disadvantaged

The traditional methods of psychotherapy (applied to anyone) were beginning to be questioned in 1952 by H. J. Eysenck. He reviewed studies on the effect of psychotherapy and concluded that these studies failed to prove that psychotherapy, regardless of the type, facilitated the recovery of neurotic patients. He concluded that this "should give pause to those who wish to give an important part of their training to clinical psychologists to a skill the existence of which is still unsupported by any scientifically acceptable evidence" (pp. 171-172). Actually, bickering over whether or not therapy is effective is not as important as addressing oneself to which people, under what kinds of situations respond to what kind of therapeutic stimuli.

It is proposed here that traditional approaches have not been effective with the socially disadvantaged, and that social class determines perception of deviance, tolerances of deviance and the kind of treatment the deviant receives. The attitudes of the therapist, therefore, become an important factor in the treatment process. Lynch et al. (1968) point out that:

. . . Most mental health professionals are unprepared, experientially or attitudinally, to treat effectively that segment of the mentally ill population who do not meet the verbal, intellectual, and motivational requirements of dynamic and insight-oriented psychotherapy. Much of the hard-core socio-economic population falls within this aggregate" (p. 428).

Although the concept of the medical model may be questioned when speaking about mental illness, Hollingshead and Redlich (1958) were basically concerned with how social class identification contributed to the recognition of the problems that an individual needed help and the kind of help he received.

Hollingshead and Redlich (1958) defined abnormal behavior as "actions that are different from what is expected in a defined social situation. Thus abnormal acts can be evaluated only in terms of their cultural and psychological contexts" (p. 171). They found that social class was the one variable that was related to type of treatment of mental illness one received.

In a study of the adjustment of the mental patient after he leaves the hospital (Freeman and Simmons, 1963)

it was found that upper-class patients perform better after discharge from a hospital than do lower-class patients. The authors postulate that this may be due to the expectations of good performance and stronger sanctions in the upper-class environment.

The psychotherapeutic relationship is a "social relationship which relies on the patient's restructuring his experiences in a verbally significant way" (Bernstein, 1964, p. 194). There is a stress, therefore, on verbalization, and a belief that communication will somehow improve conditions. This may be significant among middle-class people who have been educated to verbalize, but it is ineffective with the lower-class individual. Lower-class speech does not allow the individual to elaborate meaning very easily. It does not facilitate the verbal expression of intent, motives, beliefs and purpose or facilitate the individual in his attempt to receive these kinds of communications from others (Bernstein, 1964). Because of the kinds of speech patterns culturally induced, the lower-class person generally has not developed the sensitivity to the psychotherapeutic relationship and the kind of communication suitable in it. The speech of the therapist implies expectations which are neither understood nor met by the lower-class individual. The lower-class individual expects the therapist to be active, to quickly alleviate symptoms, to be medically oriented and wants the

therapist to act on him thus not understanding that in psychotherapy, there is mutual involvement and activity (McMahon, 1964). When the expectations of the patient are not met, there is a tendency for him to withdraw from treatment. Most of the characteristics of a classic psychotherapeutic situation are in direct conflict with the "lower-class person's experiences and expectations."

1. The traditional waiting list feeds into the middle-class deferred gratification pattern. The "lower-class" person wants immediate gratification. The future is too dismal and too uncertain to delay pleasure.

2. The waiting lists and the indefiniteness of the treatment time contradict the lower-class person's time concept of the importance of the here and now.

3. Practical concerns such as babysitting, the payment for transportation and the loss of pay if one visits the clinics during their nine to five time slot discourage the "lower-class" individual from seeking help.

4. The traits of a good prospective patient are in direct opposition to those traits generally found among the "lower class" (Bernstein, 1964). Thinking in psychological ways is important for therapy. The "lower-class" individual thinks magically. The good prospective patient has internalized his problems, tends to have a sufficient degree of self-blame, wishes to change his environment in an active manner and displays a good deal of self-control.

The lower-class individual generally projects his problems onto his environment (often realistically so), acts out in a physical way, and has a passive, often fatalistic view of life.

Since the life of the poor is different and as a result the responses of the poor, their values, mores and modes of adjustment are different, we cannot delude ourselves into thinking that the traditional psychotherapeutic approaches will be effective.

Thus the approach of traditional psychotherapy, with its complex training requirements, may not be necessary or even desirable for helping certain groups of clients. The economically disadvantaged client, for example, is generally unable to accept or profit from traditional long-term psychotherapy (Ellsworth, 1968, p. 1).

What kinds of approaches are proving effective? It is apparent that approaches which are more directive and more suggestive with less emphasis on insight are appropriate for counseling the disadvantaged. Traditional methods of psychotherapy were designed to be used by people of the same social class who share a great number of suppositions.

There have been several recent different experimental approaches to helping the disadvantaged. These have been instituted with knowledge of the general characteristics of the disadvantaged and the kinds of situations to which they will respond. These include outreach programs, group counseling, crisis intervention, role play as a form of

therapy, family therapy, and most importantly the use of the paraprofessional as a treatment agent.

Paraprofessionals in Counseling the Disadvantaged

One of the most innovative approaches to counseling the disadvantaged is the use of the paraprofessional. The paraprofessional comes from the community which he serves and can provide the client with a person with whom to identify and emulate. The high school student of low-income background who was trained to be a homework helper in the Mobilization of Youth Program for elementary school children who were doing poorly in school, served the function of a role model. The "helper therapy" concept enters here too. By helping an individual one helps oneself. Although it has not been clearly established that the poor receiving help are always benefitted, it seems fairly clear that the people giving the help in organizations like Recovery, Inc., Synanon, Alcoholics Anonymous, profit from it. The concept of "self-persuasion while persuading others" (King and Janis, 1956) and that of the improvement of self-image as well as becoming part of a system through participating in it are some of the mechanisms which operate here.

The use of paraprofessionals necessitates a clear definition of the counselor role and the establishment of

clear-cut goals in therapy. The nonprofessional can contribute to the healing function as well as the service function of agencies.

The healing function is principally concerned with the various psychological and psychotherapeutic roles within the potential repertoire of the mental health aide, guided by a professionally led team; role models (ego ideals, significant others, socializers); listener role (provide cathartic outlet); supportive role (concern); intervention role (the "intervention" effect of the presence of a therapeutic agent or person connected with therapeutic establishment such as a hospital or mental health unit--especially at crisis points); ego-expansion role--provide better understanding and awareness of reality, community resources, issues (Pearl and Riessman, 1965, p. 73).

There have been many programs which have attempted to train nonprofessional counselors. Project Cause in the summer of 1964 trained 1,754 people to work in job placement of disadvantaged youth. Because the program was conducted in haste and was short-lived, it received much criticism. One year after its conclusion, one of the twenty-seven participating institutions, the University of North Dakota, was chosen for a follow-up study on the forty-four trainees who had completed the program. Over two-thirds (thirty of forty-three) were working or receiving more training in the counseling field. Of those remaining, a majority wanted to get employment in counseling. This would indicate that the program was successful as a means of recruiting people for nonprofessional counseling positions (Johnson and Grosz, 1967).

Project Enable was the first and only project on the national level in which three national voluntary agencies collaborated their resources in order to provide opportunities for employment of the poor in nonprofessional capacities. Two hundred indigenous social work aides were given training as research interviewers. The results proved to be positive, and opened up many possibilities for using nonprofessionals as co-therapeutic agents. It is imperative, however, that the job of the nonprofessional be clearly defined in terms of scope, organization, and qualifications.

The helping professions need to reorganize the role of the professional towards increasing teaching, supervision, planning, and consultation. This reorganization would permit a greater inclusion of the indigenous nonprofessional in the giving of direct service. The professional would then be "freed up" to do those tasks which can only be performed by a professional and to supervise the nonprofessional in the services he performs. If the traditional approach has not been effective with the disadvantaged, and peer group influence is strong, then there must begin to be an increase in training indigenous people to aid the professional in his counseling function.

Finally, his new connections with poor, resulting from the increased service for the poor and from the poor, can reduce the tremendous interclass distance which has hampered the development of both the disadvantaged and the professional (Riessman, p. 251).

Indigenous paraprofessionals are those who generally come from the lower socio-economic strata of society. Many studies have indicated that social class is an important determining factor in the life of an individual (Deutsch, 1967).

Correlations between social class and mental illness were not investigated until after the Lynds' books on Middletown (1929) were published. Professionals until that time had denied the fact that social class was a part of the American culture (Moore et al., p. 149). In the late 1930's, Faris and Dunham (1939) studied the relationship between the environment and treated mental illness. Their findings indicated that a greater number of people with treated mental illness came from urban areas as compared with the suburbs. Other research also showed that a greater number of people who were diagnosed as schizophrenic came from the lower class (Hollingshead and Redlich, 1958).

The relationship between mental illness and social class was researched by others such as Imber and associates (1955). The relationship between the person's social class and his acceptability for treatment in an out-patient clinic was studied by Brill and Storow (1960). They found that there was a statistically significant tendency for people from classes I, II, and III to be

accepted for treatment in lieu of classes IV and V, if I, II, and III were grouped together.

In their intake interviewing, they found that the lower social classes had a tendency to see their problems as physical rather than emotional, desired symptomatic relief rather than overall help, had a lack of understanding of psychotherapeutic process, and lacked desire for psychotherapy, an observation also made by Rosenthal and Frank (Moore et al., 1963, p. 150).

Cole and Branch (1965) supported the thesis that social class is an important variable in psychiatric care. Social status based on economics, education and social standing is directly related to success in treatment if longevity is used as the yardstick to measure success. Because different social classes experience different conditions in their lives, their perceptions of the world are different. Hollingshead and Redlich were basically concerned with how social class identification contributed to the recognition of maladaptive behavior and the kind of help the individual received.

In 1950 Hollingshead and Redlich studied all persons who were in treatment in a psychiatric clinic or a mental hospital between May 31 and December 1, 1950, and who were residents of the urbanized community of New Haven as clearly defined by the researchers. Not included in this study were people who were receiving counseling from people other than those who were accredited to do so. Case finding was accomplished by compiling a list of all

private practitioners and psychiatrically-oriented agencies where people may get treatment.

The population used in this study was stratified using Hollingshead's Index of Social Position which measures social class identification in terms of occupation, education and place of residence. This research, a classic of its time, was basically concerned with how social class contributed to the recognition of maladaptive behavior and to the kind of treatment the individual received. Five hypotheses were formulated:

- Hypothesis 1. The prevalence of mental illness is related significantly to an individual's position in the class structure.
- Hypothesis 2. The types of diagnosed psychiatric disorders are connected significantly to the class structure.
- Hypothesis 3. The kind of psychiatric treatment administered by psychiatrists is associated with the patient's position in the class structure.
- Hypothesis 4. Social and psychodynamic factors in the development of psychiatric disorders are correlative to an individual's position in the class structure.
- Hypothesis 5. Mobility in the class structure is associated with the development of psychiatric difficulties
(Hollingshead and Redlich, 1958, p. 11).

Hollingshead and Redlich found that there were highly significant correlations between social class and the number of psychiatric patients, the type of symptoms individuals presented to their psychiatrist and the type of treatment

administered. There was no relationship found between age, sex, and treatment. Socio-economic status was the one variable related to treatment. The lowest socio-economic class tended to receive inexpensive, fast, mechanical kinds of therapy such as shock treatment, while the upper socio-economic class received talking therapy which is long-term and expensive. This study also demonstrated that the way an individual was referred for psychiatric help was determined by social class. Lower socio-economic persons tended to be referred by the court and the police.

In using as an index self-referrals, Hollingshead and Redlich found that the higher the class, the fewer were the referrals by the courts and the police. The higher the class, the greater were the proportion of patients in the population in treatment (prevalence). The data that Hollingshead and Redlich collected indicated that abnormal acts need to be evaluated in terms of their cultural context, and that social class determined the type of symptoms individuals presented as well as the type of treatment individuals received. They stated that:

The perception of the psychological nature of personal problems is a rare trait in any class, but it is found more frequently in the refined atmosphere of Classes I and II than in the raw setting of Class V. As a consequence we believe that far more abnormal behaviors are pathological, even though the behavior may be disapproved by the class norms (Hollingshead and Redlich, pp. 172-173).

Although Hollingshead and Redlich's study does not systematically demonstrate class attitudes toward deviance, it does give evidence to demonstrate the consequences of attitudes on the process of referral. Lower-class patients are more often referred for psychiatric treatment by the police courts than those of the higher class who have similar diagnoses. Patients who are of the higher socio-economic group tend to be referred for psychiatric treatment by their family or friends.

Meyers and Bean (1968) did a ten-year follow-up of those persons involved in the 1950 New Haven Psychiatric Census. This study was concerned with social class and how it determined what happened to the patient ten years following the original study. Three hypotheses were investigated:

- Hypothesis 1. Social class is related to treatment status in 1960 at follow-up.
- Hypothesis 2. Social class is related to the patient's treatment and readmission experience during the period from 1950 to 1960.
- Hypothesis 3. Social class is related to the former patient's adjustment in the community (p. 23).

Results of this study indicated that there was a significant relationship between social class and status of treatment. As the class ladder was descended, there were more patients proportionately under hospital care. Class

was also found to be a factor in treatment and readmission of former hospital patients. The higher the class the more patients were discharged in comparison to lower-class patients. Fewer lower-class patients were involved in out-patient treatment, and it is out-patient treatment which is related positively to remaining out of a psychiatric hospital. The third hypothesis, that social class is related to the discharged patient's adjustment to the community was supported by the results of this study.

C. Richard Fletcher's study of "Social Class Variations in Psychiatric Referral of Withdrawn and Aggressive Case Descriptions" (1968) examined referral decisions and the relationship between perceptions and response to deviancy according to social class. Two vignettes of an aggressive "spouse" and a withdrawn "spouse" were presented to one hundred working and middle-class couples who were randomly sampled from the City Directory of New Haven. The couples were asked to evaluate the two case descriptions on an eight-point graphic rating scale on the basis of deviance as measured by unusualness and incompatibility, and responsibility as measured by accountability and amendability. They were then asked whom they would refer the fictitious person to in order to assess the choice of helping agents. The correlations between estimates of deviance (unusualness and incompatibility)

and psychiatric referral were low. High assignment of accountability did correlate strongly with estimation of deviance. In other words, if a subject tended to see the behavior as something which the person could control, he tended to see the behavior as deviant. Fletcher found that the fictitious cases were referred for psychiatric help by the lower class almost as often as by the middle class. Fletcher therefore questioned the thesis that working-class people delay in referring for psychiatric help and that this delay causes the disproportionate number of people in the mental hospitals. Fletcher did not find any social class differences in response to deviant behavior. The research question asked in this study is whether paraprofessionals, who generally do not share the same social class with professionals in counseling, differ in their perceptions of what behavior may be considered deviant?

In a study of the adjustment of the mental patient after he leaves the hospital, Freeman and Simmons (1958) found that upper-class patients perform better after discharge from a hospital than do lower-class patients. The study group was made up of selected relatives of 649 patients who had been hospitalized for treatment of mental disorders in nine state Veterans Hospitals in Massachusetts and who had been released to live with their families during the first six months of 1959. Subjects were

limited by age (between twenty and sixty), were native born, and did not have a physical handicap which would make them unemployable. The patients had to have lived in the community for a minimum of thirty days to be considered eligible for inclusion in the study. Patients were regarded as having failed in their adjustment in the community if they had to be returned to the hospital for eleven or more days for treatment.

Freeman and Simmons indicate that:

Deviance usually is assessed with reference to some criterion of how persons should act in given situations at given times; it refers to the failure of individuals to behave in ways normatively expected of them. The emphasis in the study of deviant behavior is not only on deviance itself but also on identification of aggregates of social deviants. Establishing criteria for identifying these aggregates requires moving beyond the discrepancy between the individual's behavior and society's norms. It is necessary to be specific about responses to deviance as about deviance per se. Social deviants, as aggregates cannot be sufficiently identified by their non-conformity alone but rather by the responses of community members to their behavior (p. 212).

Although Freeman and Simmons did not find a relationship between social class and rehospitalization of mental patients, they did find a significant correlation between social class and performance level among male patients:

When a breadwinner's earnings or education are used as individual measures of social class . . . we do find significant correlations with performance levels for both male and female patients who succeed in remaining in the community. Among patients who failed there is a trend for both male and female patients who perform at high levels between hospitalizations to live in

middle-class families, and to have relatives with more education (p. 212).

High performance levels may be due, according to their speculations, to higher expectations of good performance and more intense sanctions against poor performance from families of the upper-class patients. Expectations and sanctions would be strongly influenced by perceptions of maladaptive behavior.

Perception according to the Random House Dictionary is defined as "the act or faculty of apprehending by means of the senses or of the mind" (Random House Dictionary, 1966, p. 1069). Although some of the perceptual reactions seem to be inborn, the process by which perception takes place is and can be modified by experience (Deutsch, 1968). The presence of stimuli is imperative in enhancing perception. The richer the environment, the greater the ability to discriminate (Gibson, 1958). Perception is a form of behavior, and behavior is shaped and influenced by the ways we learn to infer. Habits of inference differ in each society. Since environment and perception are closely linked, perceptual stimuli (kinds and amounts) differ with different life experiences (Segall, Campbell, and Herskovitz, 1966). Although there are few studies which define perceptual difference in terms of social class, it is suggested that because of the aforementioned statement and because social class status determines one's life

style, social class status influences perception. The perceptions of counseling paraprofessionals will therefore differ from those of counseling professionals.

Instrument Development

Shirley Star's study in 1950 dealt with the attitudes of people towards mental illness. The study was concerned with the differences of the reaction of people to figmental accounts of various kinds of mental disorders such as paranoid schizophrenia, simple schizophrenia, anxiety neurosis, alcoholism, compulsive phobic behavior, and juvenile character disorder. These six descriptions were developed with the aid of psychiatrists.

The study is based on thirty-five hundred interviews with a cross-section of the American public. For each case described, individuals were asked to determine through an interview if there was something wrong, what was wrong, the possible cause, and whether the person should or should not be labeled mentally ill. Star's study described in detail what people thought about mental illness. She found that the extreme case, the paranoid, was the only case described as mentally ill by the majority of the respondents (74 per cent). The cases had previously been developed by a group of psychiatrists all of whom agreed that all the cases represented some form of

mental illness according to the definition used by the American Psychiatric Association.

In this study, premises about human behavior were culled from probing questions concerning why the person got that way and what he can do about his difficulty. The answers to the questions were indexed by two items:

First the extent to which the person relied on early interpersonal experiences in explaining the six cases, and second the extent to which the person relied on rational self-control-willpower as a sufficient means of changing disturbed behavior (p. 6).

Star found that there was a correlation between psychiatric orientation and education which is one index of social class. A modification of Star's questionnaire was used in the study being presented here.

The Cummings' study in 1955 was based on Star's cases. This study was a controlled field experiment involving a pre- and post-test design. The Cummings investigated the direction and extent of change in attitudes towards mental illness as effected by an educational program. They used Star's open-ended interview schedule.

One overall impression emerges from the responses to these cases. The definition of mental illness is much narrower in the minds of the lay public than in the minds of psychiatrists and professional mental health workers. . . . Our interviewers were shocked at the respondents' denial of pathological conditions in the case histories, because they assumed that lay people could accept less behavior as normal. But a very wide spectrum of behavior appears to be tolerated by the laity, at least verbally, as reasonably close to normal (Cummings, 1957, pp. 100-101).

Upon further investigation, the Cummings discovered that a different set of criteria is used by lay people in determining abnormality and that these criteria are normative, and that moral standards as opposed to the assessment of psychological symptoms are used by non-professionals. Counseling paraprofessionals and counseling non-professionals were not used as subjects in this study.

The Cummings also found that those who had little education tended to express a greater degree of social distance from those who had been mentally ill than the respondents with more education. In the Cummings' study the respondents were asked whether they would exclude or include persons who had been mentally ill from certain relationships. There was less tolerance shown by the respondents from the lower socio-economic group. The present study uses the Cummings' instrument to measure the expressed social distance paraprofessionals and professionals feel toward ex-mental patients.

The social distance scale is a technique first invented by E. S. Bogardus. Respondents are asked to indicate to which steps on a particular scale they would admit members of various groups.

The Cummings' reported that:

Scores on the Distance Scale varied directly with education and inversely with age, the younger, better-educated people saying that they felt able to tolerate more contact with mental illness than the older, less well-educated (p. 57).

Lemkau and Crocetti (1962) sampled the opinion and belief of a randomly sampled population of Baltimore. This study was not designed to probe in depth those attitudes and beliefs shared with the interviewers but was devised to be of help in the administration of a program. The questionnaire used was developed through pre-testing and whenever possible, questions used in other surveys of the public's attitudes were used. Star's case stories were also used in this survey and the respondents were grouped by Hollingshead's Two-Factor Index of social status.

. . . Age, race, marital status and urban or rural birth were not significantly correlated with the tendency to make the identification. Educational level attained and the family income did make a difference in this tendency; the more educated or the higher the income, the greater the likelihood that the case stories would be considered as presenting mental illness (p. 695).

Lemkau's results differ from those of Star's and Cummings' in that there is in his study a fairly high proportion of respondents who were able to identify all the cases as mentally ill. Even though social status as measured by educational level and income did make a difference in the identification of the cases as mentally ill, Lemkau felt his study indicated an increasing awareness of the public of mental illness.

Bentz and Edgerton (1970) compared the general public (1,405 subjects) in North Carolina and Virginia who were randomly sampled, with 418 community leaders in two

predominantly rural North Carolina counties. The holding of formal positions or offices was the main yardstick used to determine the leader sample. Leaders in politics, economics, education, religion, recreation, medicine and other areas were represented. The leader sample differed from that of the general population in education, income, and occupation, all characteristics of social class status. The results of this study indicated that there were similar attitudes held by both leaders and the general public toward mental health. Both groups demonstrated more realistic information and attitudes toward mental health than the previous studies (Cummings, 1957; Star, 1950).

Bentz and Edgerton (1970) found that the general public discussed reasons for mental illness in terms of weak moral strength or inheritance, while the leaders with whom they were compared were reluctant to express judgments. In terms of the role of the mental hospital, ninety-two per cent of the leaders and eighty-six per cent of the public did not agree that a hospital can do little but give custodial care. Leaders and the public agreed in their rejection of the statement that once one is hospitalized, one's chances of being released were minimal, but significantly fewer leaders felt that hospitals are necessary to protect the community from those who are mentally ill (thirty-five versus seventy per cent).

Dohrenwend and Chin-Shong (1967) studied attitudes towards psychological disorders, contrasting community leaders with ethnic cross-sections in the Washington Heights section of New York City. These researchers were particularly concerned with the concept that lower-social-status people are more tolerant of deviance than middle- and upper-social-class individuals.

Since the usual finding is that the tendency to deny pathological conditions in these case descriptions varies with education, the inference is that tolerance of such behavior is greatest in the low-status groups (p. 419).

Thirty-four psychiatrists were asked to judge the six cases developed by Shirley Star and they almost unanimously agreed that these cases demonstrated mental illness. Mental illness was used in this study to mean "kinds of behavior which depart from psychiatric norms in such a way as to be clinically judged harmful to the individual displaying it or to others in social relationships" (Dohrenwend and Chin-Shong, p. 420). Star's six case descriptions were used. An individual was asked whether there was anything wrong with a case and if he replied in the affirmative, he was asked if he thought the person might have some kind of mental illness and regardless of whether or not he thought the person was mentally ill, he was asked whether what was wrong was serious.

The results of this study indicated that increasingly the cases are being labeled as representing "mental

illness" but that there is still a difference between the degree of seriousness these case descriptions are reported to represent. Psychiatrists tend to determine seriousness by the degree of underlying psychopathology that exists while the public judges seriousness by the degree of menace to others. The Negroes and Puerto Ricans especially tended to assess seriousness in terms of overt threat to others. As in other studies, the results of this one found that the more educated people come closest to the psychiatrists' view in their attitudes towards mental illness, and leaders indicated less social distance from ex-mental patients than the respondents from the ethnic cross-section regardless of educational level. This study also demonstrated that:

The appearance of greater tolerance of deviant behavior in low-status groups is an artifact of viewing attitudes within a high-status frame of reference. When both lower- and upper-status groups define a pattern of behavior as seriously deviant, lower-status groups are less tolerant. Moreover, the relatively tolerant policy of upper-status groups appears to be a consequence of their generally more liberal orientation rather than of comprehension of the nature of psychopathology in psychiatric terms (p. 417).

Bentz, Edgerton, and Miller reported a study in Sociology of Education, Fall, 1969, entitled "Perceptions of Mental Illness Among Public School Teachers." Three hundred ninety-six elementary school teachers from two rural counties of North Carolina participated in this study. Three hundred sixty questionnaires were returned

out of the total number left at the schools to be filled out. Whites and non-whites were represented equally. The questionnaires were designed to answer questions about the behavior of the persons described in four of Shirley Star's case descriptions. The simple schizophrenic, the alcoholic, the depressed neurotic, and the acting-out child cases were used. In comparing this study with other similar studies, one finds evidence of an increasing ability and willingness on the part of the public to label Star's case descriptions as indicative of mental illness. They were consistently more prone to do so than a random sample of residents of the same two North Carolina counties also surveyed in 1968. The comparison shows, secondly, that the teacher sample was especially likely to label behaviors described in the abstracts as mental illness (p. 406).

Summary

In this chapter the writer reviewed material which indicated that social class status was a very important influence on people in terms of behavior, values, perceptions, and attitudes. The second half of the chapter reviewed studies which were concerned with social class influence on psychiatric referral and treatment as well as its influence on tolerance of and attitudes towards mental illness.

Star's questionnaire has been utilized as an instrument for several research studies. In all of the studies the questionnaire has differentiated people with different socio-economic class in terms of their response to questions concerning perception of abnormal behavior and attitudes toward mental illness. The higher the educational level, the closer the responses are to those of the professional who by definition is middle class.

During the past fifteen years there have been several studies on perceptions and attitudes of laymen (Star, 1950; the Cummings, 1957; Lemkau and Crocetti, 1963), leaders in the community (Bentz and Edgerton, 1970; Dohrenwend and Chin-Shong, 1967), and teachers (Bentz, Edgerton, and Miller, 1969) towards mental illness. There have not, however, been reported in the literature studies which deal with the perceptions of paraprofessionals and particularly the comparison of paraprofessionals with professionals in identifying behavior which is symptomatic of mental illness. This study will attempt to add a small piece of knowledge in this area.

There is a great deal of literature in the journals relating social class to mental illness in terms of symptomatology, treatment, hospitalization, and degree of social distance from ex-mental patients (Brill and Storrow, 1960; Fletcher, 1968; Hollingshead and Redlich, 1958; Dohrenwend and Chin-Shong, 1967; Freeman and Simmons,

1963). Social class has also been related to the tolerance of deviance (Dohrenwend and Chin-Shong, 1967) and perceptions of as well as attitudes towards mental illness (Star, 1957; Dohrenwend, 1967). This study raises the question as to whether paraprofessionals with their lower socio-economic class orientation are less able to identify behavior that is considered maladaptive as defined by the APA than the professionals who are middle class.

C H A P T E R I I I

METHODS AND PROCEDURES

Introduction

This chapter describes the principal methodological operations pertinent to the development of the study described in this report. Briefly these include:

- (1) identification and description of the population;
- (2) description of the instruments; (3) methods used in collecting the information; and, (4) procedures used in analyzing collected data.

Restatement of Hypotheses

Social and psychodynamic factors in the development of maladaptive behavior are related to the person's position in the social class structure of the American society (Meyers and Roberts, 1968). Attitudes towards and tolerance of maladaptive behavior are influenced by social class status (Dohrenwend and Chin-Shong, 1967). There is a tendency, in distinctively lower-class populations, to express psychological malaise in physiological terms (Crandall and Dohrenwend, 1967). Inadequate education characterizes individuals from the lower classes (Crow, Murray, and Smythe, 1966). Because of his social class background, the paraprofessional will perceive maladaptive

behavior and express social distance from an ex-mental patient differently than the professional who is identified as a member of the middle or upper classes.

The research reported in this study investigated the following hypotheses:

1. The counseling paraprofessional and the counseling professional will differ significantly in their identification of mental illness as measured by the questionnaire developed by Star for the National Opinion Research Center of Chicago in 1950. Counseling professionals will identify a significantly (at .05 level of confidence) larger number of people as mentally ill than the counseling paraprofessional on the five vignettes developed by Star.

2. The counseling paraprofessional and the counseling professional will differ significantly (at the .05 level of confidence) in their degree of expressed social distance from an ex-mental patient as measured by the social distance scale used by Cummings.

Identification and Description of the Population

The first step taken in this research was that of identifying the counseling paraprofessionals and the counseling professionals within the greater Springfield area. This was accomplished by the researcher telephoning every agency whose manifest purpose was counseling, or

agencies which had a counseling function as part of a comprehensive program. This information was obtained from a United Fund listing and from the Community Service Directory published by the Junior League. Agencies contacted suggested names of other programs which did not have official listings.

The director of each agency was contacted by the researcher by telephone and was asked for the names and educational backgrounds of all personnel under his jurisdiction who were functioning part time or full time as psychological counselors. Many of the directors were known by the researcher. The director was told by the researcher that this information was needed in order to random sample a population for research in counseling. The researcher identified herself as a social worker, a professor at Springfield College and a doctoral student at the University of Massachusetts. Cooperation was obtained from twenty-eight agencies, but one of the private agencies and one of the state-supported agencies were reluctant to give this information. One Federally-funded agency was uncooperative. The director of one of their programs which employs a counseling paraprofessional refused to allow the researcher to speak with that person.

If reluctance to sharing information concerning personnel was expressed, the researcher then requested permission to speak with the personnel as a group in the hope

of obtaining cooperation. One agency, partially state-funded, which employed eight paraprofessionals in counseling positions could not be used. The director refused permission to the researcher to speak with her personnel. The director felt that the program was undergoing change and that the paraprofessionals were feeling tenuous about their position. Taking part in a research project might therefore be unsettling for them.

Locating paraprofessionals and obtaining permission to speak with them was the main obstacle encountered in this research. Since nine paraprofessionals were not made available to the researcher, the geographic area from which the population was drawn had to be enlarged. This was accomplished by listing all the towns and cities abutting the greater Springfield area, and identifying the agencies and the personnel within them. In order to obtain a minimum of twenty counseling paraprofessionals the area was expanded to include all the towns north of Springfield as far as and including Northampton, Massachusetts, east to and including Monson, Massachusetts, south to Windsorville, Connecticut, and as far west as and including Russell, Massachusetts (see Appendix D).

The second obstacle in obtaining subjects was the limiting definition of what constitutes a counseling paraprofessional. The original definition limited the paraprofessional to be an indigenous person who had a high

school education or less and who had been exposed to a minimum of a two-week training program in counseling. In identifying paraprofessionals in the area, the researcher found that very often, as part of their training, they have had one or more college courses. A paraprofessional, therefore, was redefined to include an indigenous person who had no more than fifteen semester hours of college courses, who was not enrolled in a degree program and who had been exposed to a minimum of a two-week training program. Using this definition thirty paraprofessionals were identified. Of the thirty, twenty-one expressed interest in cooperating. One of the latter had a terminal degree in nursing and was therefore eliminated from the research.

One hundred thirty professionals were identified. Twenty of the professionals to be used in this research were chosen by the use of a table of random numbers. Fourteen had master's degrees in social work; three were Ph.D. counseling psychologists, and three had master's degrees in counseling and psychology. All of the professionals agreed to cooperate. In one situation a person was eliminated from the research because the degree the person had was not in counseling, psychology, or social work. In another case, one of the professionals who came up in the random sampling was hospitalized as a result of an automobile accident and was therefore unable to be interviewed.

Another professional was drawn randomly from the pool of the one hundred thirty individuals.

After the population was identified and permission received from the director of the agency, the researcher made a telephone contact with the potential interviewee. The researcher stated:

I am a professor at Springfield College. I have a master's degree in social work and am presently completing my doctorate in counseling at the University of Massachusetts. I am doing some research in counseling and need your cooperation. Could you spare about an hour or so to answer a questionnaire that one of my interviewers will give to you?

If they answered affirmatively, they were told the name of the interviewer who would be contacting them and thanked for their cooperation.

In order to insure participation and especially because of the difficulty the researcher had in finding the paraprofessional population, the paraprofessionals were paid \$3.00 each for the interview. Professionals were also contacted in this fashion with the same introduction, although they were not paid for their involvement in this study.

The interviewees were then contacted by phone by the interviewers who arranged to see them. Seventeen of the interviews with the professionals and fourteen of the interviews with the paraprofessionals were held in the offices of their respective agencies. The remaining were interviewed as requested in their home.

The specific purpose of the research was not explained to the respondents and was not known by the interviewers who administered the criterion instrument. It was instead identified basically as research on people doing counseling.

Sixty per cent of the paraprofessional respondents were married, fifteen per cent were single and twenty-five per cent were divorced. Seventy per cent of the professionals were presently married. Twenty-five per cent were single and five per cent were divorced.

By definition, all the professionals who participated in this study had a minimum of a master's degree. The paraprofessional formal education ranged from completion of grammar school (ten per cent), some high school (five per cent), completion of high school (fifty-five per cent), to some college (thirty per cent).

The mean age of the paraprofessionals was thirty-four compared with a mean of thirty-two for the professionals. The ages of the paraprofessionals ranged from twenty to fifty-five. The professionals' age range was twenty-one to sixty-three. Forty per cent of the paraprofessionals had lived in their present community for five to nineteen years, while twenty-five per cent had been living in the same area for twenty years or more. Thirty per cent of the paraprofessionals had remained in their present community for twenty years or longer, forty-five per cent for five to nineteen years, and twenty-five per cent had been in

their community for five years or less. Seventy-five per cent of the professionals owned their own home. Forty-five per cent of the paraprofessionals were in this classification.

The median family income of the paraprofessionals fell within the \$5,000 to \$7,500 bracket while the median family income of the professionals fell within the \$10,000 and over category.

Sixty per cent of the twenty paraprofessionals and seventy per cent of the twenty professionals were female. All of the professionals and fifty-five per cent of the paraprofessionals interviewed were white.

The Instruments

One of the instruments used for this study was a modification of Star's questionnaire developed by the National Opinion Research Center in Chicago in 1950. Star, with psychiatric consultation, developed a series of six cases depicting a paranoid, a simple schizophrenic, an anxiety neurotic, an alcoholic, a compulsive-phobic personality, and an example of childhood behavior disorder. All but the vignette describing the childhood behavior disorder were used for this study. This vignette was not used because the case history did not adequately describe what the American Psychiatric Association would consider a behavior disorder.

The instrument was originally developed as a result of preliminary interviewing and the pretesting indicated validity of the contents. Star hypothesized that four of the six cases (omitting the alcoholic and the childhood behavior disturbances) which are most easily classified into the categories of psychosis and neurosis, formed a scale of ninety-nine per cent reproducibility. There was no coefficient correlation given.

The vignettes used in this study have been used five times subsequent to their development by Star (1950). In all but one of the studies in which they were utilized (Lemkau and Crocetti, 1960), the ability to identify the behaviors described as maladaptive differed with educational level, which is a measure of social class (Cumming and Cumming, 1957; Karno and Edgerton, 1969; Dohrenwend and Chin-Shong, 1967).

Star's interview schedule was used by Dohrenwend and Chin-Shong (1967) in their study of attitudes towards mental illness on the part of community leaders in Washington Heights in New York City, in contrast to ethnic cross-sections of that area. Prior to using the six vignettes developed by Star to represent mental illness, thirty-four psychiatrists were asked to give opinions about the cases. Dohrenwend and Chin-Shong state that since the psychiatrists were unanimous in viewing the case descriptions as exemplifying mental illness, "the descriptions do

indeed provide an illustrative, though not completely representative, sample of the kinds of behavior with which we are concerned" (p. 40).

In addition to the Star interview questionnaire, the Cummings Social Distance Scale (Appendix C) was given to each of the respondents. This scale consists of ten questions to which respondents were asked to agree or disagree. The scale measures expressed interpersonal social distance from ex-mental patients. It quantifies how close a relationship an individual expresses willingness to tolerate with someone who has been confined to an institution because of mental illness. The eight statements to which the respondents were asked to reply "Agree" or "Disagree" to how close they would relate to an ex-mental patient ranged on a scale from as close as marriage to as distant as renting an apartment to him. The technique was invented by E. S. Borgadus in 1924. Basically, it is a technique of using a verbal attitude as a method of attempting to assess what action a person would take when confronted with the object of his attitude. "Scales are a psychophysical measurement of an underlying dimension; an attempt to place a symbol system in some relationship to a psychological state according to a specified set of rules, in this instance feelings of social distance. . . ." (Amoy and Sakuna, 1969, p. 8).

The eight items used on the Cummings Social Distance Scale had been analyzed by them by Guttman's method of "scaleability". Each item on the scale was tested by the Cummings and all the items were found to be uni-dimensional; that is to say that the scale measured a single attitude and not a combination of attitudes which are related. The scale had been pretested by the Cummings before their use of it in their Blackfoot study.

Methods Used in the Collection of Data

The method used in this research to collect information was that of the personal interview. The Star questionnaire and the Cummings Social Distance Scale were administered to a random sample of twenty professionals and to all the paraprofessionals identified who were willing to cooperate. The questionnaire contained specifically pre-determined questions related to the problem being researched in exact words to be used, and the exact sequence in which questions were to be asked (see Appendix A). This helped to minimize interviewer bias.

The time for the interview ranged from one hour to one and one-half hours. Interviewers were two married females. One was a graduate student in her early thirties, working towards her master's degree in counseling at the University of Massachusetts. The other interviewer was a twenty-one-year-old female undergraduate majoring in

community leadership at Springfield College. The interviewers were not appraised of the hypotheses formulated for this research.

Training for the interviewing consisted of a two-hour systematic review of each question on the instruments. The interviewers were trained by the researcher in exactly what to say in clarifying the intent of the question and received training in how to probe for clarification or elaboration of responses, since the questionnaire consists of areas in which probing is necessary. To encourage respondents to elaborate their responses the interviewers were taught to ask open-ended questions such as, "What do you mean by this?" Where probing was required, the words used to probe were specifically spelled out for the interviewer on the questionnaire. For instance, for the question, "What do you think makes him act this way?" the probe was, "What's causing him to act this way?" followed by, "What happened to make him act like this?"

Because the interviewers were middle-class, they were trained to neutralize their class differences by not giving any clues which would reflect social class.

Interviewers administered the criterion instrument to each other and to two additional people receiving feedback from the placebo respondents on the facial expression, voice and other non-verbal communications from the interviewers. Training took a total of five hours. Both

interviewers were people with whom rapport can be established easily. The type of field which they were both studying generally attracts people who relate well to others.

All of the questions were read by the interviewer to the respondents. While reading the case descriptions and the list of causes of emotional illness, the interviewer handed the respondent a card on which the same material was written. This gave the respondents an opportunity to review the data instead of trying to commit them to memory.

Stages in the Interview

1. The first stage in the interview was the introduction by the interviewer. The fact that the research concerned people doing counseling was reiterated.

2. Star's small vignettes comprised the core content of the interview schedule. They depict in everyday language, imaginary people who symptomatically suffer from what psychiatrists generally consider to be psychiatric disorders. For each situation described, the respondent was asked a series of uniform questions.

"Would you say that there is anything wrong with this man or not?"

"What do you think makes him act this way?"

"Would you say that he has some kind of mental illness?"

"Why do you say that he does (does not) have a mental illness?"

If the respondent answered "has" or "depends" to this question, he was then asked, "Would you say that the mental illness he has is a serious one or not?" and, "Why do you say it is (is not) serious?"

Finally, respondents were asked to respond to the question and probes in the context of why they thought the individual described was behaving in that particular way.

These questions were designed to explore the ability to identify "something wrong" in the behavior of the individual described in the case illustration and the willingness to label the behavior as symptomatic of mental illness.

3. Following these questions, the schedule contained queries concerning people who are not "out of their minds" but who do have emotional problems. Respondents were handed a card containing twelve possible reasons for emotional illness such as excessive drinking, growing old, etc., which would not necessarily cause a complete breakdown. Respondents were asked to choose the ones, if any, they felt could cause emotional difficulty.

4. The respondents were then asked to respond to the statements on the social distance scale in terms of agreement or disagreement.

5. The last stage of the interview consisted of obtaining factual data concerning age, income, education, and length of time respondents had resided in the area.

Procedures Used in Analyzing Collected Data

Each of the questions on the questionnaire and also on the social distance scale which required one of several alternative responses was analyzed in terms of the percentage of paraprofessionals and the percentage of professionals who gave each of the responses. Chi-square was also computed for each question to determine the statistical significance of the difference between the two groups. The median test was used to determine the significance of the difference in the answers between the two groups, the professionals and the paraprofessionals. This test is useful in determining "whether the observed sample differences signify differences among populations or whether they are merely the chance variations that are expected among random samples from the same populations" (Siegel, 1956).

For each vignette, the interviewer was asked to make several probes around the question, "What do you think makes him act this way?" The purpose behind this was to find out about the respondent's psychiatric orientation. The concept of psychiatric orientation is based on the premise that there are a group of hypotheses which are interrelated, concerning human behavior.

Star points out that the case descriptions as indicative of mental illness are based on defining the deviant behavior as illustrations in which the paramount patterns of behavior and emotions are severely inappropriate and maladaptive to the reality situation. This type of definition emerges out of a conceptualization of human behavior which is based on three basic premises:

First, that--The basic exploratory scheme is presumed to be applicable to all human behavior whether it is ultimately classified as deviant or non-deviant.

Second, that--The ultimate causes of characteristic emotional patterns are usually attributed to early interpersonal experiences rather than to immediate stimuli external to the individual psyche or to deliberate, conscious, individual choices.

And, third, that--Characteristic emotional patterns are, therefore, to be regarded as not entirely within the rational control of the individual and as easily modifiable. Modifications of behavior patterns which depend entirely on the rationality of the deviant person on self-help, will power, appeals to reason, logical exhortation and the like--or on purely environmental alterations are generally perceived to be inadequate to the difficulty (Star, 1957, p. 6).

Based on this approach to human behavior, the researcher utilized Star's premises to score the question following each vignette, "What do you think makes him act this way?" An example of a rational-normative approach would be the response that the person is behaving in a particular manner because "he had an experience in life." The psychiatric orientation would allude to early interpersonal experiences as causation. The response for each respondent could range from five "P's" to five "R's".

Two female professionals were asked to do the ratings. One had a master's degree in social work from the University of Connecticut School of Social Work which she received in 1964. She has been working as a case worker for the Children's Protective Society of Holyoke. The other rater was a Ph.D. psychologist. She received her doctorate degree from Baylor University in 1961. She then worked for two years as a counselor and is presently teaching psychology at Western New England College. Using the Phi-coefficient, rater reliability was found to be .60.

The raters placed a "P" for those answers which indicated a psychiatric orientation, an "R" for those which were more rational in approach, and a "P-R" for those which combined both a rational and a psychiatric orientation.

Summary

This chapter detailed the methodological approach to the research. The method of identifying counseling paraprofessionals and counseling professionals was outlined. The characteristics of the interviewers and their training were discussed; the instrument used was outlined as well as the way in which the data from the instruments was analyzed. The following chapter will include a detailed analysis of the data collected.

CHAPTER IV

ANALYSIS OF DATA

Introduction

The data collected by interview questionnaire were analyzed to determine whether there would be a significant difference between the two different populations--counseling professionals and counseling paraprofessionals in their perceptions of maladaptive behavior and expressed social distance from ex-mental patients. Directional hypotheses were based on the definition that paraprofessionals, by and large, come from a lower socio-economic class than professionals. Past research has also indicated that social class is influential in determining perception of and attitudes towards mental illness.

Analysis consisted of comparing responses to specific answers given by the two groups concerning their perception of Star's vignettes as indicating maladaptive behavior, whether the behavior described was indicative of mental illness and whether the illness was perceived as serious.

Chi-square was computed for all the quantifiable questions and the median test was used to determine the significance of the difference between the two groups. A detailed description of the statistical findings is presented in this chapter.

Analysis of Data--Hypothesis I. The counseling paraprofessionals and the counseling professionals will differ in their identification of mental illness as measured by the attitude questionnaire developed by Star for the National Opinion Research Center of Chicago. Counseling professionals will identify a significantly larger number of people (at the .05 level of significance) as mentally ill than the counseling paraprofessionals on the five vignettes developed by Star.

As part of the interview each respondent was asked questions about the case vignettes. The interviewer read each case to the respondent and then the respondent was asked whether there was anything wrong with the person. If he answered "yes" or "depends", he was then asked whether the person described had some kind of mental illness.

The hypothesis that the counseling professionals would identify fewer of the vignettes as illustrative of maladaptive behavior than counseling paraprofessionals was analyzed.

As shown in Table 1, in response to the first illustration depicting a paranoid, nineteen paraprofessionals (ninety-five per cent) and twenty professionals (one hundred per cent) responded that there was something wrong. One paraprofessional (five per cent) responded that he did not know if there was something wrong. Since one cell

went to 0, no χ^2 was run; however, similarity of the response would lead us to doubt the significance of the five per cent difference.

Table 1

Percentage of Respondents Judging Paranoid Case in
Star's Vignettes as Something Wrong,
Nothing Wrong, or Don't Know

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Something wrong	95	100
Nothing wrong	0	0
Don't know	5	0
Total	100	100

To the question whether the man depicted had some kind of mental illness, eighty per cent of both the professional and paraprofessionals labeled this case as depicting mental illness. In Table 2, it can be seen that ten per cent of the professionals and five per cent of the paraprofessionals said "he had not". Five per cent of the professionals answered "don't know" as compared with none of the paraprofessionals. "Depends", was an answer given by five per cent of the professionals and fifteen per cent of the paraprofessionals.

Table 2

Percentage of Respondents Judging Paranoid Description in
Star's Vignettes as Indicative of Mental Illness

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Has	80	80
Has not	5	10
Depends	15	5
Don't know	0	5
Total	100	100
	$X^2 = .26$	
	$P > .05$	
	NS	

Those who answered "has" or "depends" to the question concerning whether the man described is mentally ill, were then asked to decide whether the illness was serious or not. As Table 3 demonstrates, eighty per cent of the paraprofessionals considered the illness serious as compared with eighty-eight per cent of the professionals. Slightly more professionals, therefore, identified the paranoid case as having a serious mental illness than paraprofessionals. Of the paraprofessionals, five per cent answered "not serious", five per cent "depends", ten per cent "don't know".

Chi-square indicated no significant difference at .05 level of confidence between paraprofessionals and

professionals in the way they responded to the three questions concerning the case of the paranoid individual.

Table 3
Percentage of Respondents Judging Paranoid
Description in Star's Vignettes as Serious

Judgments	Paraprofessionals (N=20)	Professionals (N=17)
Serious	80	88
Not serious	5	0
Depends	5	12
Don't know	10	0
Total	100	100
	$\chi^2 = .26$	
	$P > .05$	
	NS	

The second case in Star's vignettes described a young girl, Betty, who symptomatically is suffering from simple schizophrenia. The question, "Would you say there is something wrong with this girl or not?" drew ninety-five per cent "something wrong" from the professionals and ninety per cent from the paraprofessionals. Five per cent of the professionals answered "don't know" as did ten per cent of the paraprofessionals (see Table 4). Again the zero cell existed; hence, no χ^2 was computed, but due to the similarity of the distributions one would not think the five per cent difference to be significant.

Table 4

Percentage of Respondents Judging Schizophrenic Case
in Star's Vignettes as Something Wrong

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Something wrong	90	95
Nothing wrong	0	0
Don't know	10	5
Total	100	100

The data in Table 5 show that forty per cent of the professionals stated that Betty had a mental illness, ten per cent answered that she had not, forty per cent stated it depends, and ten per cent did not know. On the other hand, seventy per cent of the paraprofessionals saw the behavior as indicative of mental illness, fifteen per cent answered "has not", and ten per cent "don't know" and five per cent "depends".

Table 5

Percentage of Respondents Judging Schizophrenic Case
in Star's Vignettes as Indicative of Mental Illness

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Has	70	40
Has not	15	10
Depends	5	40
Don't know	10	10
Total	100	100
	$\chi^2 = 5.14$ $P > .05$ NS	

As Table 6 shows, of those who agreed that Betty was mentally ill or answered "depends", a small majority of professionals (fifty-six per cent) considered the condition described as serious. Seventy-three per cent of the paraprofessionals considered the condition serious.

Table 6

Percentage of Respondents Judging Schizophrenic Case
in Star's Vignettes as Serious

Judgments	Paraprofessionals (N=15)	Professionals (N=16)
Serious	73	56
Not serious	20	6
Depends	7	32
Don't know	0	6
Total	100	100
	$\chi^2=1.82$ $P>.05$ NS	

The third in Star's case vignettes described a depressed neurotic, George Brown. As the results in Table 7 indicate, one hundred per cent of the professionals and eighty-five per cent of the paraprofessionals thought there was something wrong with George. Of the paraprofessionals who did not answer "something wrong", ten per cent stated that they did not know and five per cent saw the behavior as normal.

Table 7

Percentage of Respondents Judging Anxiety Neurotic Case
Description in Star's Vignettes as Something Wrong

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Something wrong	85	100
Nothing wrong	5	0
Don't know	10	0
Total	100	100
	$\chi^2 = .60$	
	$P > .05$	
	NS	

Table 8 shows that thirty per cent of the professionals saw the behavior as symptomatic of mental illness as compared with twenty-five per cent of the paraprofessionals. Twenty per cent of the professionals and ten per cent of the paraprofessionals answered "don't know" while twenty per cent of the professionals compared with forty-five per cent of the paraprofessionals answered "depends".

Table 8

Percentage of Respondents Judging Anxiety Neurotic Case
Description in Star's Vignettes as Indicative
of Mental Illness

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Has	25	30
Has not	20	30
Depends	45	20
Don't know	10	20
Total	100	100
	$\chi^2=1.50$ $P>.05$ NS	

As indicated by the data in Table 9, a small minority of both paraprofessionals and professionals considered George Brown's illness serious. Forty per cent of the professionals and nineteen per cent of the paraprofessionals considered the illness to be not serious.

Table 9

Percentage of Respondents Judging the Anxiety Neurotic
Case Description in Star's Vignettes as Serious

Judgments	Paraprofessionals (N=14)	Professionals (N=10)
Serious	31	20
Not serious	19	40
Depends	19	0
Don't know	31	0
Total	100	100
	$\chi^2 = .64$	
	$P > .05$	
	NS	

The next case among Star's vignettes was Bill Williams, an alcoholic. All of the professionals and paraprofessionals stated that there was something wrong (see Table 10). There was no difference between the distributions.

Table 10

Percentage of Respondents Judging the Alcoholic Case
Description in Star's Vignettes as Something Wrong

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Something wrong	100	100
Nothing wrong	0	0
Don't know	0	0
Total	100	100

Table 11 indicates that forty per cent of the professionals and fifty-five per cent of the paraprofessionals told the interviewers that the symptoms were indicative of mental illness. More paraprofessionals (ten per cent) as compared with professionals (five per cent) were unable to make a decision on this issue.

Table 11

Percentage of Respondents Judging the Alcoholic
Case Description in Star's Vignettes as
Indicative of Mental Illness

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Has	55	40
Has not	25	35
Depends	15	15
Don't know	5	10
Total	100	100
	$\chi^2 = .30$	
	$P > .05$	
	NS	

Of those who stated that Bill Williams was mentally ill, or answered "depends", seventy-nine per cent of the paraprofessionals and seventy-three per cent of the professionals stated that the illness was serious (see Table 12).

Table 12

Percentage of Respondents Judging the Alcoholic
Description in Star's Vignettes as Serious

Judgments	Paraprofessionals (N=14)	Professionals (N=11)
Serious	79	73
Not serious	14	0
Depends	7	27
Don't know	0	0
Total	100	100
	$\chi^2=2.32$ $P>.05$ NS	

The last case description was that of Mary White, a phobic girl with compulsive features. As Table 13 indicates, seventy-five per cent of the paraprofessionals and eighty-five per cent of the professionals said that there was something wrong with this girl, but only twenty-five per cent of the professionals and twenty per cent of the paraprofessionals thought the girl was mentally ill. Thirty-five per cent of the professionals and twenty-five per cent of the paraprofessionals said she was not, while forty per cent of the professionals and thirty-five per cent of the paraprofessionals answered "depends", "don't know" (see Table 14).

Table 13

Percentage of Respondents Judging Compulsive-Phobic Case
Description in Star's Vignettes as Something Wrong

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Something wrong	75	85
Nothing wrong	20	5
Don't know	5	10
Total	100	100
	$\chi^2 = .84$	
	$P > .05$	
	NS	

Table 14

Percentage of Respondents Judging Compulsive-Phobic
Case Description in Star's Vignettes as
Indicative of Mental Illness

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Has	20	25
Has not	25	35
Depends	15	20
Don't know	40	20
Total	100	100
	$\chi^2 = .88$	
	$P > .05$	
	NS	

None of the paraprofessionals and only eleven per cent of the professionals considered Mary White's illness serious (see Table 15). Both paraprofessionals and professionals answered "depends" to the question pertaining to the seriousness of the problem.

Table 15

Percentage of Respondents Judging Compulsive-Phobic Case Description in Star's Vignettes as Serious

Judgments	Paraprofessionals (N=7)	Professionals (N=9)
Serious	0	11
Not serious	29	34
Depends	58	22
Don't know	13	33
Total	100	100
	$\chi^2=.16$	
	$P>.05$	
	NS	

Chi-square was computed for each of the responses to the questions relating to Star's case vignettes. Significance was established at the .05 level of confidence. There was no statistically significant difference found between the professionals and paraprofessionals on any of the responses. The median test was also used to compare the two groups, the counseling professionals and the counseling paraprofessionals in terms of the significance

of the difference between them in the number who responded "something wrong", "has mental illness", and "serious" to the vignettes. Significance was established at the .05 level, and the analysis of the data showed no significant difference between the two groups in terms of the manner in which they answered the questions concerning whether the case histories described maladaptive behavior, whether the behavior was symptomatic of mental illness and whether or not the illness was serious.

Hypothesis I which stated that the counseling professionals would identify a significantly larger number of people in Star's vignettes as mentally ill than counseling paraprofessionals cannot be accepted based on data collected in this study.

Analysis of Data--Hypothesis II. The counseling paraprofessional and the counseling professional will differ significantly (at the .05 level of significance) in their degree of expressed social distance from an ex-mental patient as measured by the social distance scale developed and used by Cummings.

In assessing how people feel about being around an individual who had been hospitalized because of mental illness, respondents were asked whether or not they would feel any different than being around an individual who had not been so hospitalized. Seventy per cent of the paraprofessionals and sixty-five per cent of the professionals

stated that they would feel no different. Fifteen per cent of the paraprofessionals and thirty per cent of the professionals admitted to "feeling different" while none of the professionals and fifteen per cent of the paraprofessionals answered that it would "depend". Five per cent of the professionals answered "don't know".

Table 16

Percentages of Responses to the Question on Star's Questionnaire: "If you found out that someone you knew who seemed all right now had been in a mental hospital once, do you think you'd feel any different about being around this person?"

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Would feel different	15	30
No different	70	65
Depends	15	0
Don't know	0	5
Total	100	100
	$\chi^2=1.78$ $P>.05$ NS	

Only twenty-five per cent of the paraprofessionals stated that they would treat an ex-mental patient differently than they would treat someone else. Thirty-five per cent of the professionals affirmed that they would treat these people differently.

As Table 17 indicates, paraprofessionals and professionals responded similarly to the questions on the Cummings Social Distance Scale except for the statements, "I can imagine myself falling in love with a person who has been mentally ill," and "If I were a resident owner of an apartment house, I would hesitate to rent living quarters to a former mental patient." Seventy-five per cent of the professionals and ninety-five per cent of the paraprofessionals agreed with the first statement. Fifty-five per cent of the professionals and seventy-five per cent of the paraprofessionals answered "disagree" to the second statement.

A Chi-square Test indicated no significant difference at the .05 level of confidence for any of the answers in the Cummings Social Distance Scale except for Question Number Two which read, "I can imagine myself falling in love with a person who has been mentally ill." In this instance a Chi-square Test indicated that the probability is less than .05 that the difference in the answers between the paraprofessionals and the professionals to this question could have occurred by chance.

Table 17

Percentages of Respondents Willing to Accept an Ex-Mental Patient
On Eight Social Distance Items

Social Distance Item	Response	Profes- sionals (N=20)	Parapro- fessionals (N=20)	X ²	P	Difference
We would strongly discourage our children from marrying anyone who has been mentally ill.	Disagree	80	85 ^a			
I can imagine myself falling in love with a person who had been mentally ill.	Agree	75	95	3.45	<.05	Significant ^b
I would be willing to room with a former mental patient.	Agree	100	90	.52	>.05	NS ^c
If I were a resident owner of an apartment house, I would hesitate to rent living quarters to a former mental patient.	Disagree	55	75	.88	>.05	NS
If I were employed at a job, I wouldn't hesitate to share my office with someone who had been mentally ill.	Agree	95	85	.28	>.05	NS
If I owned an empty lot beside my house, I would be willing to sell it to a former mental patient.	Agree	95	95			
I wouldn't work for anyone who had been mentally ill.	Disagree	95	95			
I would be willing to sponsor a person who had been mentally ill for membership in my favorite club or society.	Agree	95	90			

^aDue to the existence of a zero cell, no X² test of significance was computed; however, one may assume that since a ten per cent difference of similar distributions was not significant at (P<.05), a five per cent difference would also fail to be significant.

^bChi-square test indicates that the difference between the paraprofessionals and the professionals on this question could not have occurred by chance.

^cNS=Not Significant.

The median test indicated no significant difference (at the .05 level) between the paraprofessionals and the professionals on the Cummings Social Distance Scale. Hypothesis Two, therefore, was not supported by the data collected in this study.

To the question, "Do you think that most people would feel the same way that you do about being around a person who had once been in a mental hospital or not?" eighty per cent of the paraprofessionals and seventy-five per cent of the professionals answered "different" (see Table 18). Again zero cells exist, but the five per cent difference in distributions is not deemed significant.

Table 18

Percentages of Responses to the Question: "Do you think that most people would feel the same way that you do about being around a person who once had been in a mental hospital or not?"

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Same	10	15
Different	80	75
Don't know	10	10
Total	100	100

In an effort to assess on what basis individuals made their judgments concerning people who had been hospitalized, respondents were asked whether they knew anyone who had been institutionalized and if yes, who they were. Ninety-five per cent of both the paraprofessionals and the professionals answered this question affirmatively (see Table 19). Hence, the two distributions were the same. In five per cent of both groups the person who had been institutionalized was the respondent. Close friends and acquaintances comprised the bulk of the contacts for both groups. As Table 20 indicates, thirty-five per cent of the professionals and twenty per cent of the paraprofessionals referred to other people, mainly clients they had worked with. Fifteen per cent of the paraprofessionals and ten per cent of the professionals mentioned members of the immediate family, while other relatives were mentioned by thirty per cent of the professionals and five per cent of the paraprofessionals.

Table 19

Percentages of Responses to the Question: "Did you ever know anyone who was in a hospital because of a mental illness?"

Responses	Paraprofessionals (N=20)	Professionals (N=20)
Yes	95	95
No	5	5
Not sure	0	0
Total	100	100

Table 20

Percentages of Responses to the Question: "Whom do you know who was in a mental hospital?"

Responses	Paraprofessionals (N=20)	Professionals (N=20)
Respondent	5	5
Immediate Family	15	10
Other Relatives	5	30
Close Friends	35	40
Acquaintances	30	55
Other	20	35
Won't say	0	0

In answering the question on the Star questionnaire, "Would you say that everyone who has a mental illness is out of his mind . . . insane, or not?" seventy per cent of the professionals answered "not insane" and thirty per cent

answered "depends". This parallels the paraprofessionals, sixty-five per cent of whom answered "not insane" and thirty-five per cent "depends" (see Table 21). No significant difference is attributed to the five per cent difference in distributions.

Table 21

Percentages of Respondents Correlating Mental Illness
With Being Out of One's Mind or Insane

Judgment	Paraprofessionals (N=20)	Professionals (N=20)
Insane	0	0
Not insane	65	70
Depends	35	30
Don't know	0	0
Total	100	100

Definition of nervous breakdown. As the results in Table 22 indicate, a nervous breakdown was considered to be a mental illness by thirty per cent of the professionals and forty per cent of the paraprofessionals. Ten per cent of the professionals stated that it was not, compared with thirty-five per cent of the paraprofessionals. Fifty per cent of the professionals and twenty-five per cent of the paraprofessionals answered this question by stating that "it depends".

Table 22

Percentage of Respondents Correlating Nervous
Breakdown With Mental Illness

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Is	40	30
Is not	35	10
Depends	25	50
Don't know	0	10
Total	100	100
	$\chi^2=3.38$ $P > .05$ NS	

Respondents were also asked whether emotional problems and nervous conditions other than those which are not considered "insane" have the same causes. The data in Table 23 indicate that seventy-five per cent of the paraprofessionals and fifty per cent of the professionals answered "some same, some different" to this question, with fifteen per cent of the paraprofessionals and ten per cent of the professionals stating that they did not know. Fifteen per cent of the professionals and five per cent of the paraprofessionals stated that the causation was different. Twenty-five per cent of the professionals and five per cent of the paraprofessionals stated that causation was the same.

Table 23

Percentages of Respondents Answering Question: "Do less severe nervous conditions have same causes as insanity or not?"

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Same as insanity	5	25
Different	5	15
Some same, some different	75	50
Don't know	15	10
Total	100	100
	$\chi^2=2.40$ $P>.05$ NS	

Respondents were handed a card which listed twelve items of things which could happen to people. They were then asked to check those items which by themselves could cause people to have an emotional or nervous sickness without losing their minds. The items were:

- (1) Too much brain work
- (2) Drinking too much
- (3) Not enough will power, lack of self-control
- (4) Masturbation (playing with oneself, self-abuse)
- (5) Sex habits
- (6) Money troubles
- (7) Trouble getting along with one's husband or wife
- (8) Trouble getting along on the job
- (9) A run-down physical condition
- (10) Growing old
- (11) Not being loved as a child
- (12) Poor heredity, family inheritance (a family history of this kind of sickness.

Table 24

Percentages of Respondents Indicating Situations Which By Themselves
Could Cause Emotional Illness Without "Insanity"

Situations	Professionals	Paraprofessionals
1. Too much brain work	25	35
2. Drinking too much	35	55
3. Not enough will power, lack of self-control	15	20
4. Masturbation (playing with oneself, self-abuse)	15	15
5. Sex habits	25	20
6. Money troubles	30	50
7. Trouble getting along with one's husband or wife	40	60
8. Trouble getting along on the job	40	35
9. A run-down physical condition	20	35
10. Growing old	35	25
11. Not being loved as a child	75	45
12. Poor heredity, family inheritance (family history of this kind of sickness)	40	25

As Table 24 indicates, seventy-five per cent of the professionals and forty-five per cent of the paraprofessionals considered lack of love during childhood as a situation which by itself can create emotional difficulty. More paraprofessionals (fifty-five per cent) than professionals (thirty-five per cent) saw too much drinking as adequate causation for emotional difficulty.

Table 25

Rank Order of Responses by Paraprofessionals
Indicating Situations Which By Themselves
Could Cause Emotional Illness
Without "Insanity"

-
1. Trouble getting along with one's husband or wife.
 2. Drinking too much.
 3. Money troubles.
 4. Not being loved as a child.
 5. Too much brain work.
Trouble getting along on the job.
A run-down physical condition.
 6. Growing old.
Poor heredity, family inheritance (a family history of this kind of sickness).
 7. Not enough will power, lack of self-control.
Sex habits.
 8. Masturbation.
-

Table 26

Rank Order of Responses By Professionals Indicating
Situations Which By Themselves Could Cause
Emotional Illness Without "Insanity"

-
1. Not being loved as a child.
 2. Trouble getting along with one's husband or wife.
Trouble getting along on the job.
Poor heredity, family inheritance (a family history of this kind of sickness).
 3. Drinking too much.
Growing old.
 4. Money troubles.
 5. Too much brain work.
Sex habits.
 6. A run-down physical condition.
 7. Masturbation.
Not enough will power, lack of self-control.
-

Fifty per cent of the paraprofessionals as compared with thirty per cent of the professionals viewed money problems as a source by itself of emotional difficulty (see Table 23).

Forty per cent of the professionals and twenty-five per cent of the paraprofessionals felt that poor family heredity could cause emotional illness. Symptoms such as marital strife and excessive drinking were more often seen by the paraprofessional than the professional to be conducive to creating emotional illness. A higher percentage

of paraprofessionals than professionals saw sex habits, difficulty on the job, and growing old to be causations of difficulty.

Prognosis of mental illness. Table 27 indicates that an equal number of paraprofessionals and professionals (sixty per cent) answered that people who have less severe nervous conditions than "insanity" can get over them and forty per cent of both groups answered that "some can and some cannot".

Table 27

Percentages of Responses to the Question: "Do you think that people who have less severe nervous conditions can get over them, or not?"

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Can	60	60
Cannot	0	0
Some can, some cannot	40	40
Don't know	0	0
Total	100	100

"Can they get over these conditions by themselves or do they need help to get over them?" drew the responses indicated below in Table 28. None of the respondents felt that they could get over the conditions by themselves;

twenty-five per cent of the professionals and thirty-five per cent of the paraprofessionals stated that help was necessary; fifty per cent of the professionals and forty-five per cent of the paraprofessionals answered "both"; and twenty per cent of the paraprofessionals and twenty-five per cent of the professionals stated that "it would depend". Again zero cells exist, but the five per cent difference in distribution is not deemed significant.

Table 28

Percentages of Responses to the Question: "Can they get over these conditions by themselves or do they need help to get over them?"

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
By themselves	0	0
Need help	35	25
Both	45	50
Depends	20	25
Don't know	0	0
Total	100	100

Perception of helping agents. In answering the open-ended question on Star's questionnaire, "Who can help with their problems?" half of the professionals and thirty per cent of the paraprofessionals specifically named social

workers. More than half (fifty-five per cent) of the paraprofessionals and only thirty-five per cent of the professionals named psychiatrists as helping agents and forty per cent of the paraprofessionals and thirty-five per cent of the professionals stated that friends can be of therapeutic help. Psychologists were named as helping agents by fifty per cent of the professionals and thirty per cent of the paraprofessionals, while clergy were named by thirty per cent and thirty-five per cent of the respective groups. As Table 29 indicates, the psychiatrist and the social worker were seen by a greater number of paraprofessionals than professionals as helping agents. The psychologist was named by half of the professionals as a helping agent in comparison with thirty per cent of the paraprofessional. Twice as many professionals viewed the paraprofessional as a helper than the paraprofessionals did.

Table 29

Percentages of Responses to the Question: "Who can help those people who have less severe nervous conditions with their problems?"

	Paraprofessional	Professional
Clergyman	35	30
Psychiatrist	55	35
Psychologist	30	40
Social Worker	30	50
Family	20	20
Counselor	30	20
Work	5	0
Paraprofessional	5	10
Physician	25	35
Friends	40	35

Table 30 indicates that in assessing prognosis for those people who "go out of their minds," ninety per cent of the professionals and sixty-five per cent of the paraprofessionals registered positive prognosis. None of the professionals and five per cent of the paraprofessionals felt that nothing could be done to help, while thirty per cent of the paraprofessionals and ten per cent of the professionals answered "depends" to this question.

Table 30

Percentages of Responses to the Question: "Once a person goes out of his mind, is there anything that can be done to help him get better again?"

Responses	Paraprofessionals (N=20)	Professionals (N=20)
Yes	65	90
No	5	0
Depends	30	10
Don't know	0	0
Total	100	100
$\chi^2=1.64$ $df=2$ $P>.05$ NS		

Table 31 indicates that more paraprofessionals (fifty-five per cent) than professionals (twenty per cent) responded that a person "who goes out of his mind" should be placed in a mental institution, with forty per cent of the paraprofessionals and seventy-five per cent of the professionals answering "depends".

Table 31

Percentages of Responses to the Question on Star's Questionnaire: "Should a person who goes out of his mind be placed in a mental hospital?"

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Should	55	20
Should not	5	0
Depends	40	75
Don't know	0	5
Total	100	100
$\chi^2=4.44$ $df=2$ $P>.05$ NS		

As Table 32 indicates, to the question asking whether people who are "insane are dangerous to be around," none of the professionals and fifteen per cent of the paraprofessionals replied affirmatively. Eighty-five per cent of the professionals and sixty per cent of the paraprofessionals answered "are not" with the remaining number not being able to answer either way.

Table 32

Percentages of Responses to the Question: "Do you think most people who are insane are dangerous to be around, or not?"

Judgments	Paraprofessionals (N=20)	Professionals (N=20)
Are	15	0
Are not	60	85
Don't know	25	15
Total	100	100
	$\chi^2=1.44$ $df=1$ $P>.05$ NS	

Two raters, both professionals in counseling, were asked to rate the questions relating to Star's vignettes which asked, "What do you think makes him act this way?" and the question, "Can they get over these nervous conditions by themselves, or do they need help to get over them?" A response which was considered to be based on a psychiatric premise was given a "P". One which was based on a normative-rational premise was given an "R", and "P-R" was assigned to those responses which combined both premises. The Phi-coefficient was used to find the correlation between the two raters. Correlation was found to be .60.

The median test indicated an χ^2 equaling 2.86 which is significant at the .05 level of confidence. There was

a significant difference found between the premises used to explain the behaviors in the case vignettes by the paraprofessionals and the professionals. The paraprofessionals tended more to explain the behaviors from a normative-rational point of view while the professionals used a psychiatric premise.

Summary

This chapter reviewed the analysis of the data collected. Both hypotheses presented:

1. The counseling paraprofessionals and the counseling professionals will differ significantly in their identification of mental illness as measured by Star's questionnaire. Counseling professionals will identify a significantly (.05 level) larger number of people as mentally ill than the counseling paraprofessional on the five vignettes developed by Star;
2. The counseling paraprofessionals and the counseling professionals will differ significantly (.05 level) in their degree of expressed social distance from an ex-mental patient as measured by the Cummings Social Distance Scale;

cannot be accepted based on the data collected in this study.

The following chapter will discuss in detail the possible implications of the findings.

C H A P T E R V

DISCUSSION

Introduction

The main purpose of this study was to compare counseling paraprofessionals with counseling professionals in their perceptions of maladaptive behavior and their attitudes towards people who have been labeled as having been mentally ill. A secondary purpose was an exploration of the basic premises about human behavior that both paraprofessionals and professionals used in making decisions about whether or not a person's behavior may be symptomatic of mental illness, and the seriousness of the illness.

The Cummings Social Distance Scale and Star's questionnaire were used by trained interviewers to collect the data from a total population of twenty paraprofessionals and twenty professionals randomly sampled.

Percentages were computed and Chi-square and the median test were the statistical techniques employed to analyze the data.

Findings

Findings concerning each of the hypotheses reveal the following:

1. The counseling paraprofessionals and the counseling professionals do not differ significantly in their identification of mental illness as measured by the Star questionnaire. Counseling professionals did not, as the researcher hypothesized, identify a significantly larger number of people (at the .05 level) as mentally ill than the paraprofessionals on the five vignettes developed by Star.

2. There was a significant difference (at the .05 level of confidence) between the counseling paraprofessional and the counseling professional on only one item on the Cummings Social Distance Scale. A significantly larger number of paraprofessionals than professionals answered "agree" to the statement, "I can imagine myself falling in love with a person who has been mentally ill." The researcher's hypothesis that the scale would reveal a greater degree of social distance by the paraprofessionals on all items was therefore not supported.

Conclusions and Implications

Recognizing that someone is ill involves two phases: perception and labeling. Perception refers to an observer's "feeling" that something is wrong--that the person is behaving in a way which is not considered normal. Labeling refers to the process by which an individual verbalizes this perception (Edgerton, 1969). Perception

and labeling can be two separate processes, although perception often leads to labeling. However, a person may be perceived as behaving in a strange manner but may not be identified as suffering from a mental illness. Every culture has certain labels which it applies to people who are acting inappropriately according to the status they occupy in that society. These terms in English include "crazy", "insane", "having a nervous breakdown", "psychotic", etc.

The results obtained from the Star questionnaire in the research being reported do not support the thesis that paraprofessionals differ from the professionals in their ability to identify maladaptive behavior even though they come from different social classes. Both paraprofessionals and professionals designated persons as mentally ill only if they were severely and chronically psychotic and if their behavior was potentially destructive to themselves or to others. Those respondents who answered "has not" to the questions concerning whether the behavior described in the vignettes was symptomatic of mental illness made comments concerning the rationale for their decision, such as:

"Mental illness is destructive and negative-needing commitment."

"He has a physical illness."

"He is coping with reality maintaining a job. He is making an adjustment but not perfect."

"An awful lot of people live to die in this state."

"Symptoms described are more common to a neurotic type of anxiety."

Mental illness seemed to be defined as something which is destructive and included only psychotic behavior.

Respondents were reticent, however, to label as mentally ill those people who behaved strangely and differently from behavior expectations in their culture but whose symptoms were not as dramatic as those of the psychotic. In all of the case descriptions the paraprofessionals' responses approximated those of the professionals'. There was a tendency to see something wrong in all five of the vignettes. In labeling the something wrong as indicative of mental illness, the paraprofessionals' responses were identical with the professionals' in reference to the paranoid case.

The responses of the two groups differed slightly with the anxiety neurotic, the alcoholic, and the compulsive phobic. The widest disparity in labeling the cases indicative of mental illness existed in reference to the simple schizophrenic. Seventy per cent of the paraprofessionals stated that the schizophrenic described in the vignette was mentally ill compared with forty per cent of the professionals. These data contradict the findings of past studies (Cummings and Cummings, 1957, and Lemkau and Crocetti, 1962) which revealed a steady increase throughout

the years in the tendency by respondents to describe all of Star's vignettes as depicting mental illness in approximation of the responses of the psychiatrists to whom the vignettes were originally presented. These results are also different from those of past studies (Lemkau and Crocetti, 1962, and Cummings and Cummings, 1957) which have shown a correlation between education and class with the ability to identify the cases as describing mental illness. Despite the disparity in education and class, there was no statistical significance between the paraprofessionals and the professionals in identifying behavior as indicative of mental illness in the present study.

There have been distinct differences in the attitudes of the general public towards problems of mental disorder. People of different educational levels especially have differed in their perceptions of maladaptive behavior. The present research does not reflect this. There was no significant difference in perception between the paraprofessionals (whose educational level has not generally gone beyond high school), and the professionals who by definition have a minimum of a master's degree.

Star's nationwide survey in 1950 indicated that the general public did not come to the same conclusions about what constituted mental illness as did the psychiatrists. Seventeen per cent of the respondents did not perceive any of the case descriptions as indicating behavior

sufficiently deviant to be called mental illness as compared with the psychiatrists, all of whom viewed all the cases as depicting people abnormal enough to be called mentally ill. Most of Star's respondents labeled the paranoid, the case where violence was prominently indicated, as exemplifying mental illness. In the present research the responses of the professionals paralleled those of Star's general public except at a higher percentage.

The paraprofessionals' responses deviated from Star's study particularly in the case of the schizophrenic and the alcoholic. With these two cases, the deviation was in the direction of findings from other research (Lemkau and Crocetti, 1963; Dohrenwend, Bernard, and Kolb, 1962; Bentz et al., 1967). These researchers had postulated that there was an increase in perception on the part of the general public in terms of identifying behaviors indicative of mental illness. Researchers have indicated that these changes in perceptions and attitudes have occurred as a result of the educational efforts of agencies and organizations concerned with problems of mental health. It appears that the paraprofessionals have also been influenced by this increased education so that they too reflect this trend (Bentz and Edgerton, 1970).

What about the professional? Why has he consistently in this research labeled fewer cases mentally ill than respondents in other research (Dohrenwend and Chin-Shong,

1967), and why was he less prone to identify the schizophrenic and the alcoholic as being mentally ill than was the paraprofessional?

It is difficult to speculate why paraprofessionals more frequently identified the schizophrenic as being mentally ill than professionals. The comments by the professionals concerned the possibility that Betty Smith's behavior might be a reaction to a recent traumatic experience.

There seems to be an increasing awareness of the influence of severe environmental difficulty on precipitating a crisis situation for an individual. If Betty's symptoms were reactions to a sudden crisis, then she would have a good reason to be depressed and withdrawn. If reasons for her symptoms were based on reality factors, she would therefore not be mentally ill according to the professionals. It may be that the paraprofessional who comes from the lower class views this behavior as non-functional, since Betty is withdrawing from her environment instead of aggressively attempting to deal with it.

The fact that all of the professionals sampled were white and that about half of the paraprofessionals were black may have had some influence on the results of this research. Grier and Cobbs (1968) indicate that black Americans develop traits which are considered to be psychopathological by whites but which are necessary traits for

adaptation to a hostile environment. One such trait is distrust which functions to protect the person from physical harm. To survive, the black man, according to Grier and Hobbs, must develop a cultural paranoia, a suspiciousness of society. This does not involve withdrawal.

In attempting to understand the possible factors involved in the judgments made of the vignettes, one must understand the definitions of mental illness which an individual holds. The professionals used the word "psychosis" more often than any other word as a synonym for mental illness. Nervous breakdown was seen as presenting less extreme behaviors than psychosis by some and as a term used by laymen to mean anything from psychosis to psychoneurosis by others. Mental illness was described as symptomatic of behavior which is unpredictable, inappropriate, extreme and irrational. If Betty Smith's behavior was a reaction to a reality situation, then she would not be diagnosed as psychotic and would therefore not be considered mentally ill.

The paraprofessionals viewed mental illness in terms of being unable to function adequately in everyday life, not behaving normally, demonstrating bizarre behavior which could be potentially dangerous to themselves or to others. Although Betty Smith did not demonstrate

potentially violent behavior, the paraprofessionals saw her behavior as indicative of mental illness.

The alcoholic was also seen by more paraprofessionals than professionals as being mentally ill. Both groups approximated each other in judging the seriousness of the illness for the alcoholic.

The percentage of respondents in this study who identified the alcoholic as suffering from a mental disease was less than that of other studies done since 1960 (Lemkau and Crocetti, 1962; Dohrenwend and Chin-Shong, 1967; Bentz et al., 1969). This may be a function of the increasing number of alcoholics (from 4,500,000 in 1960 to an estimated six million plus). Massachusetts ranks fourth highest in the United States with an estimated 200,000 people suffering from alcoholism (Massachusetts Department of Public Health Report on Alcoholism, 1971). Alcoholism is becoming more common and therefore more like the norm. There has been, also, an educational campaign for the public which tends to make the behavior of the alcoholic more understandable. If the behavior is understandable, then it is less likely to be viewed as unpredictable which characterizes the respondents' definition of psychosis and therefore mental illness.

Both paraprofessionals and professionals were more likely to judge those cases as serious in which the behavior posed a threat to the individual or to others. Note that

with both groups the rank order of seriousness starts with the paranoid. The alcoholic is seen as next in terms of degree of seriousness with the schizophrenic, the anxiety neurotic and the compulsive phobic considered serious in that order. This finding is similar to that of Dohrenwend and Chin-Shong (1967) in their study of urban leaders compared with ethnic groups in New York City. They found that their respondents tended to judge seriousness in terms of the degree of overt threat to others. This finding was in contrast to the results they obtained from thirty-four psychiatrists. The simple schizophrenic rated second in degree of seriousness while in the present research this case rated third as with Dohrenwend's community respondents.

The important distinction in terms of judging seriousness on the part of the professionals is that the cases judged to be most serious were those which threatened others--the paranoid and the alcoholic. The schizophrenic, the anxiety neurotic, and the compulsive phobic behavior, which involved harm primarily to the individual, were judged to be less serious. The paraprofessionals, however, ranked the schizophrenic as serious as the potentially violent cases.

The responses of professionals to the degree of seriousness of the behavior depicted in Star's vignettes in the present research more closely paralleled that of the responses of the general public as presented by Star

and Dohrenwend and Chin-Shong. The responses of both the paraprofessionals and the professionals are divergent from those of the psychiatrists in previous studies and seem to parallel the thinking of the general public. This may be a result of a growing trend away from the psychodynamic orientation towards behavior and a greater emphasis on behavioral definitions and behavioral approaches to therapy. It may also reflect the differences between the training received by the psychiatrists and other counseling professionals.

There was a distinct tendency among the respondents in this research not to judge the depressed neurotic and the compulsive phobic as mentally ill and not to judge these cases as serious. The word "mental illness" may have a negative connotation.

There has been a movement away from the medical model of viewing pathological behavior. This model has been under attack from many people (Szasz, 1963; Goffman, 1961; and Scheff, 1963). They have postulated that mental illness is a myth which gives power to physicians to judge the behavior of others. Arguments concerning the importance of diagnosis based on social roles of individuals and the role expectations of their cultural group have been offered. Edgerton (1969) has stressed that social factors play an important role in the diagnosis of psychiatric disorders. Behavior is not viewed as maladaptive or functional in a

vacuum but is assessed in terms of the culture in which the individual lives. Gursslin, Hunt, and Roach (1964) theorized that the model for mental health is equal to the model for middle-class behavior and mores.

The corollary to the proposition that the mental health movement is functional for the middle-class sociocultural structure is that it is dysfunctional for the lower socio-economic structure since it promulgates an ethic which is contrary to some of the central values and orientation of lower-class society (Gursslin et al., p. 64).

It is possible that this type of philosophy has become more prevalent among counseling professionals and also, therefore, been shared by them with the counseling para-professionals who come from the lower class.

Being a member of a particular subcultural group may result in an individual behaving in a manner normal to his subculture. It is members of the larger culture (middle and upper class) who more often diagnose mental illness as such (Zusman, 1966).

It is also true that mental illness becomes a status symbol. Persons who are labeled as such are viewed as a special group of people to be feared, pitied, and stigmatized even after their maladaptive behavior has been eradicated (Sarbin, 1969). This may account for the reticence among professionals and paraprofessionals to label case descriptions as indicating mental illness in spite of the fact that in every case the respondents perceived something wrong.

It is possible that the changing focus of psychiatry has been operative. A newer approach considers self-fulfillment to be the goal of treatment and also to be one of the most important goals in life. It implies that individuals need not "adjust" to society. A self-fulfillment philosophy suggests that an individual's struggle toward goals which are personally productive and which create meaning for his life (London, 1969) is important. This approach supports a greater acceptance of differences in behavior and therefore a tendency not to label differences as indicative of mental illness.

An overwhelming majority of the professional respondents (ninety per cent) viewed the prognosis for those having severe mental illness as good, but under three-quarters (sixty-five per cent) of the paraprofessionals anticipated a positive prognosis. In this area, the class status of the paraprofessionals may have been influential. The recovery rate for members of the lower socio-economic class in our society is less than that of the middle or upper classes. Meyers and Roberts (1958) found that there was a positive relationship between class and treatment. As one moved up the socio-economic scale, there was a higher rate of successful treatment.

Meyers and Bean (1968) found that the percentage of people discharged from a mental institution varies significantly with social class. The higher the social class,

the higher the percentage of discharges. They also found that the proportion of patients readmitted to a mental hospital decreases with an increase in social class. The paraprofessionals may be basing their judgments on situations they have witnessed in their community.

Marital difficulty was viewed by a sizeable majority of paraprofessionals (sixty per cent) to be a cause of emotional difficulty without necessarily leading to psychosis. Drinking ranked second, money problems third and not being loved as a child ranked fourth. The professionals overwhelmingly (seventy-five per cent) found childhood deprivation of love first and trouble on the job, marital strife, and poor heredity tied for a very distant second (forty per cent). Paraprofessionals appear to view symptoms as the cause of difficulty as compared with the professionals whose psychiatric orientation expresses itself in the tendency to view early childhood experiences as crucial.

Statistically, a significant difference was found between the paraprofessionals and the professionals in terms of their psychiatric orientation towards behavior. In explaining causation, the paraprofessionals more often relied on the normative-rational approach, which does not take into consideration the influence of early interpersonal experiences.

Although the paraprofessionals and professionals in this research were able equally to identify behavior as maladaptive and as indicative of mental illness, there was a significant statistical difference in the rating they received for the basic premises they used to make decisions concerning the behaviors described in Star's vignettes. Fewer paraprofessionals based their decisions on psychiatric premises than did the professionals. This may be a function of their educational level. This finding agrees with that found by Star (1957) in her nationwide study. She found that the "psychiatrically-oriented subculture is made up predominantly of intellectuals, and urban intellectuals at that; they're college educated, professionals, and all the correlates of those two" (p. 9).

Social Distance From Ex-Mental Patients

The only significant difference found between the two groups, the counseling paraprofessionals and the counseling professionals, on measurements of social distance was related to Question Number Two of the eight questions on the Cummings Social Distance Scale. This was concerned with whether or not an individual could envision himself falling in love with an ex-mental patient. There were more positive responses to this question by the paraprofessionals than by the professionals.

The Cummings in their study found the tendency for respondents to express a greater social distance from those who have been mentally ill than towards other people in the community. They also found that the acceptance of those who had been mentally ill was affected positively by the education of the respondents. In the study being reported there appeared to be a tendency for the paraprofessionals to demonstrate a greater acceptance in some areas than the professionals. This again, is inconsistent with the Cummings' findings. Both paraprofessionals and professionals in the present research were least prone to rent living quarters to an ex-mental patient if the respondent was living in the same house, but expressed a greater acceptance of their children marrying an ex-mental patient. Since marriage is considered the closest personal relationship on the scale, it is surprising that this relationship could be more acceptable than one in which the ex-patient is a person living in the same building. Perhaps the fact that marriage was expressed in the question to involve children of the respondents and not the respondents themselves made the relationship more acceptable.

Limitations

1. Findings in this research are limited to the Star questionnaire and the Cummings Social Distance Scale only.

2. One of the basic limitations in this research may have been the validity of the instruments used. Questionnaires and attitude scales measure what a person says he will do but they do not measure behavior. The question can therefore be raised as to how the attitudes expressed on the social distance scale would be translated into behavior. Kutner, Wilkins, and Yarrow (1952) found that although individuals may be ethnically prejudiced, this attitude is not necessarily expressed in discriminatory behavior. Would the respondents to the social distance scale translate into behavior how they stated they felt they would behave towards an ex-mental patient?

3. The third limitation in this research may have been the population of paraprofessionals available. Although thirty paraprofessionals were identified, only twenty were made available for this research. Would the ten who did not participate have different attitudes from those who did?

4. Another limitation in this research is the fact that all of the professionals drawn were white while almost half of the paraprofessionals were black. What are the implications of the differences in racial composition?

Implications For Further Research

There are several implications for further research that involve comparisons of paraprofessionals with

professionals. Another study encompassing a larger geographical area and including a larger sample, randomly sampled is indicated. This would provide a broader base and therefore result in findings which would have greater generalizeability.

Analysis of the extent of training and kind of training paraprofessionals are receiving would be helpful in understanding why their perceptions of maladaptive behavior, mental illness and perceptions of the seriousness of an illness, so closely approximated those of the professionals. Further study in training of paraprofessionals is needed in order to determine how to help the paraprofessionals increase their expertise in identifying psychopathology but also to better understand the dynamics of the behavior of clients.

Research should be expanded to involve perceptions of counseling professionals in order to learn whether changes have taken place in the diagnosis of mental illness. These changes could have important influences on the definition of psychopathology, the classification of people as being mentally ill, as well as the type of treatment which is made available.

Further study of attitude change may be indicated. Paraprofessionals of lower socio-economic class and less education than professionals have expressed similar attitudes toward the mentally ill. It may very well be that

attitudes are less difficult to change than has been previously assumed.

This research indicates that paraprofessionals from a lower socio-economic class were able to perceive mental illness in the same manner that it was perceived by professionals. If paraprofessionals and professionals reflect different social classes, then class differences in attitudes reported by other researchers must be questioned.

Paraprofessionals can have a useful function in community mental health projects. We need to know more concerning the kinds of training which help the paraprofessional become better able to function in a counseling capacity. Perceiving behavior as maladaptive is the very first step in counseling.

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A P P E N D I X A

QUESTIONNAIRE

National Opinion Research Center
University of Chicago

1. Of course, everybody hears a good deal about physical illness and disease, but now, what about the ones we call mental or nervous illness? . . . When you hear someone say that a person is "mentally-ill," what does that mean to you? (PROBES: How would you describe a person who is mentally ill? What do you think a mentally-ill person is like? What does a person like this do that tells you he is mentally-ill? How does a person like this act?)

2. Would you say that everyone who has a mental illness is out of his mind . . . insane, or not?
 - Insane
 - Not insane
 - Depends
 - Don't know
 - A. (IF "NOT INSANE" OR "DEPENDS") What is the matter with the ones who aren't insane then? (PROBES: How would you describe them . . . the ones who aren't insane? What are they like? How do they act?)

3. As far as you know, what is a nervous breakdown? (PROBES: How would you describe it? What is it like? What happens to a person who has one? How does he act?)
 - B. Would you say that a nervous breakdown is a mental illness or not?
 - Is
 - Is not
 - Depends
 - Don't know
 - (1) (IF "IS", "IS NOT", OR "DEPENDS" TO B) What are your reasons for saying that it is (is not) a mental illness?

4. Now I'd like to describe a certain kind of person and ask you a few questions about him . . . I'm thinking of a man--let's call him Frank Jones--who is very suspicious; he doesn't trust anybody, and he's sure that everybody is against him. Sometimes he thinks that people he sees on the street are talking about him or following him around. A couple of times, now, he has beaten up men who didn't even know him, because he thought that they were plotting against him. The other night, he began to curse his wife terribly; then he hit her and threatened to kill her, because, he said, she was working against him, too, just like everyone else.

Would you say that there is anything wrong with this man, or not?

Something wrong
Nothing wrong
Don't know

SPONTANEOUS COMMENT:

IF "SOMETHING WRONG" OR "DON'T KNOW", ASK A AND B.
IF "NOTHING WRONG", ASK A.

- A. What do you think makes him act this way? (PROBES:
What's causing him to act like this? What happened to make him like this?)

ASK B OF EVERYONE EXCEPT "NOTHING WRONG'S" TO QUESTION 7.

- B. Would you say this man--Frank Jones--has some kind of mental illness or not?

Has
Has not
Depends
Don't know

IF "HAS" OR "DEPENDS", ASK (1) AND (2).
IF "HAS NOT", ASK (1).

- (1) Why do you say that he has (does not have) a mental illness?

- (2) Would you say that the mental illness he has is a serious one or not?

Serious
Not serious
Depends
Don't know

- (a) (IF "SERIOUS", "NOT SERIOUS", OR "DEPENDS") Why do you say it is (is not) serious?

5. Now here's a young woman in her twenties, let's call her Betty Smith . . . She has never had a job, and she doesn't seem to want to go out and look for one. She is a very quiet girl, she doesn't talk much to anyone--even her own family, and she acts like she is afraid of people, especially young men her own age. She won't go out with anyone, and whenever someone comes to visit her family, she stays in her own room until they leave. She just stays by herself and daydreams all the time, and shows no interest in anything or anybody.

Would you say that there is anything wrong with this young woman or not?

Something wrong
Nothing wrong
Don't know

SPONTANEOUS COMMENT:

IF "SOMETHING WRONG", OR "DON'T KNOW" TO QUESTION 8, ASK A AND B.

IF "NOTHING WRONG", ASK A.

- A. What do you think makes her act this way? (PROBES: What's causing her to act like this? What happened to make her like this?)
- B. Would you say this young woman--Betty Smith--has some kind of mental illness or not?

Has
Has not
Depends
Don't know

IF "HAS" OR "DEPENDS" ASK (1) AND (2).
IF "HAS NOT", ASK (1).

- (1) Why do you say that she has (does not have) a mental illness?
- (2) Would you say that the mental illness she has is a serious one or not?

Serious
 Not serious
 Depends
 Don't know

- (a) (IF "SERIOUS", "NOT SERIOUS", OR "DEPENDS") Why do you say it is (is not) serious?

6. Here's another kind of man; we can call him George Brown. He has a good job and is doing pretty well at it. Most of the time he gets along all right with people, but he is always very touchy and he always loses his temper quickly, if things aren't going his way, or if people find fault with him. He worries a lot about little things, and he seems to be moody and unhappy all the time. Everything is going along all right for him, but he can't sleep nights, brooding about the past, and worrying about things that might go wrong.

Would you say that there is anything wrong with this man or not?

Something wrong
 Nothing wrong
 Don't know

SPONTANEOUS COMMENT:

IF "SOMETHING WRONG". OR "DON'T KNOW", ASK A AND B.
IF "NOTHING WRONG", ASK A.

- A. What do you think makes him act this way? (PROBES: What's causing him to act like this? What happened to make him like this?)

ASK B OF EVERYONE EXCEPT "NOTHING WRONG'S" TO QUESTION 6.

- B. Would you say this man--George Brown--has some kind of mental illness or not?

Has
Has not
Depends
Don't know

IF "HAS" OR "DEPENDS" ASK (1) AND (2).
IF "HAS NOT", ASK (1).

- (1) Why do you say that he has (does not have) a mental illness?
- (2) Would you say that the mental illness he has is a serious one or not?

Serious
Not serious
Depends
Don't know

- (a) (IF "SERIOUS", "NOT SERIOUS", OR "DEPENDS") Why do you say it is (is not) serious?

7. How about Bill Williams? He never seems to be able to hold a job very long, because he drinks so much. Whenever he has money in his pocket, he goes on a spree; he stays out till all hours drinking, and never seems to care what happens to his wife and children. Sometimes he feels very bad about the way he treats his family; he begs his wife to forgive him and promises to stop drinking, but he always goes off again.

Would you say that there is anything wrong with this man or not?

Something wrong
Nothing wrong
Don't know

SPONTANEOUS COMMENT:

IF "SOMETHING WRONG" OR "DON'T KNOW", TO QUESTION 7, ASK A AND B.
IF "NOTHING WRONG", ASK A.

- A. What do you think makes him act this way? (PROBES: What's causing him to act like this? What happened to make him like this?)
- B. Would you say this man--Bill Williams--has some kind of mental illness or not?

Has
Has not
Depends
Don't know

IF "HAS" OR "DEPENDS" ASK (1) AND (2).
IF "HAS NOT", ASK (1).

- (1) Why do you say that he has (does not have) a mental illness?
- (2) Would you say that the mental illness he has is a serious one or not?

Serious
Not serious
Depends
Don't know

- (a) (IF "SERIOUS", "NOT SERIOUS", OR "DEPENDS") Why do you say it is (is not) serious?

8. Here's a different sort of girl--let's call her Mary White. She seems happy and cheerful; she's pretty, has a good enough job, and is engaged to marry a nice young man. She has loads of friends; everybody likes her, and she's always busy and active. However, she just can't leave the house without going back to see whether she left the gas stove lit or not. And she always goes back again just to make sure she locked the door. And one other thing about her: she's afraid to ride up and down in elevators; she just won't go anywhere where she'd have to ride in an elevator to get there.

Would you say that there is anything wrong with this young woman or not?

Something wrong
Nothing wrong
Don't know

SPONTANEOUS COMMENT:

IF "SOMETHING WRONG" OR "DON'T KNOW", ASK A AND B.
IF "NOTHING WRONG", ASK A.

- A. What do you think makes her act this way? (PROBES:
What's causing her to act like this? What happened
to make her like this?)

ASK B OF EVERYONE EXCEPT "NOTHING WRONG'S" TO
QUESTION 8.

- B. Would you say that this young woman--Mary White--
has some kind of mental illness or not?

Has
Has not
Depends
Don't know

IF "HAS" OR "DEPENDS" ASK (1) AND (2).
IF "HAS NOT" ASK (1).

- (1) Why do you say that she has (does not have) a
mental illness?
- (2) Would you say that the mental illness she has
is a serious one or not?

Serious
Not serious
Depends
Don't know

- (a) (IF "SERIOUS", "NOT SERIOUS", OR
"DEPENDS") Why do you say it is (is
not) serious?

9. Well, we've been talking about different kinds of
people and what makes them act the way they do . . .
Now let's talk about people who go out of their minds,
go insane . . . What causes people to go out of their
minds? (What else could cause people to go insane?)

10. Now, how about people who aren't out of their minds, but do have emotional problems or nervous conditions . . . Would you say that these less severe nervous conditions have the same causes as insanity or not?

Same as insanity
 Different
 Some same, some different
 Don't know

- A. (IF "DIFFERENT" OR "SOME SAME, SOME DIFFERENT")
 What would you say causes people to get into these less severe nervous conditions? (Can you think of anything else which would cause nervous conditions in people?)

11. (HAND RESPONDENT CARD) Now here is a list of different things that could happen to people . . .

- A. Is there anything on this list which would be enough, by itself, to cause people to have an emotional or nervous sickness, without losing their minds? Which ones? (Any others?)

- (1) Too much brain work
- (2) Drinking too much
- (3) Not enough will-power, lack of self-control
- (4) Masturbation (playing with oneself, self-abuse)
- (5) Sex habits
- (6) Money troubles
- (7) Trouble getting along with one's husband or wife
- (8) Trouble getting along on the job
- (9) A run-down physical condition
- (10) Growing old
- (11) Not being loved as a child
- (12) Poor heredity, family inheritance (a family history of this kind of sickness)

All of them
 None of them
 Combination of them
 Don't know

- B. Is there anything on this list which would be enough, by itself, to cause people to lose their minds? Which ones? (Any others?) (Record responses above.)

- C. (IF "SEX HABITS" OR "ALL OF THEM" TO A OR B)
 You just said that sex habits might cause people to develop nervous conditions or lose their minds . . . What did you have in mind? (Were you thinking of anything else? What?)

12. Now, talking about people who have these nervous conditions, without being out of their minds . . .

Do you think people who have these less severe nervous conditions can get over them, or not?

Can
 Cannot
 Some can, some cannot
 Don't know

- A. (IF "CAN" OR "SOME CAN") Can they get over these nervous conditions by themselves or do they need help to get over them?

By themselves
 Need help
 Both
 Depends
 Don't know

IF "BY THEMSELVES", ASK (1).
IF "NEED HELP", ASK (2) AND (3).
IF "BOTH" OR "DEPENDS", ASK (1), (2) AND (3).

- (1) What can they do by themselves to get better? (Anything else?)
 (2) Who could help with their problems? (Anyone else?) (IF "DOCTOR", PROBE: Any special kind of doctor?)
 (3) What do you think these people could do that would help?

13. Now let's take a person who loses his mind . . . Once this person goes out of his mind, is there anything that can be done to help him get better again?

Yes
 No
 Depends
 Don't know

IF "YES", ASK A.

IF "NO", ASK B.

IF "DEPENDS", ASK A AND B.

A. What can be done for him? (Anything else?) (IF "DOCTOR", PROBE: Any special kind of doctor?)

B. Why not? (Why can't anything be done?)

14. Do you think a person who goes out of his mind should be placed in a mental hospital (asylum) or not?

Should
Should not
Depends
Don't know

(1) (IF "SHOULD", "SHOULD NOT", OR "DEPENDS") Why do you think he should (should not) be placed in a mental hospital?

15. Do you think MOST insane people are dangerous to be around, or not?

Are
Are not
Don't know

A. (IF "ARE") What makes it dangerous to be around them?

16. Do you think it might do people harm in any (other) way to be around someone who is insane?

Yes
No
Depends
Don't know

A. (IF "YES" OR "DEPENDS") How might it be harmful?

17. If you found out that someone you knew who seemed all right now had been in a mental hospital (asylum) once, do you think you'd feel any different about being around this person?

Would feel different
No different
Depends
Don't know

IF "WOULD FEEL DIFFERENT", ASK A.

IF "NO DIFFERENT" OR "DON'T KNOW", ASK B.

IF "DEPENDS", ASK A AND B.

- A. How do you think you'd feel about being around him (her)?
- B. Do you think you would treat a person who had once been in a mental hospital any differently than you treat other people? (How would you treat him (her)?)

18. Do you think that most people would feel the same way that you do about being around a person who had once been in a mental hospital (asylum) or not?

Same
Different
Don't know

- A. (IF "DIFFERENT") How do you think most people would feel about being around this person?

19. Did you ever know anyone who was in a hospital (asylum) because of a mental illness?

Yes
No
Not sure

- A. (IF "YES") Was this a relative, a close friend, or just someone you didn't know very well?

Respondent
Immediate family
Other relatives
Close friends
Acquaintances

Other (Specify)
Won't say

20. You know, some experts say that one out of every ten people in the United States will have some kind of mental illness or nervous condition in the course of their lives. And right now, over half the hospital beds in the country are occupied by people who are mentally ill . . .

What do you think can be done about this problem--the large amount of mental illness in this country?

Factual Data

1. What was the name of the last school you attended?

What was the last grade or year you completed in that school?

Master's Degree	In what?
Completed college	
Some college	
Completed high school	
Some high school	
Completed grammar school	
Some grammar school	
No formal education	

2. Are you married at present?

Single
Divorced, separated
Widowed
Married

- A. (IF EVER MARRIED) Do you have any children?

Yes
No

- (1) (IF "YES" TO A) How old are your children?

All under 18
Some under 18, some 18 or older
All 18 or older

3. A. What religion do you consider yourself?

Protestant
Catholic
Jewish
Other
None

4. What is your age? (About)

5. What is your home address?

Street _____ City _____

6. How long have you lived in this town?

Less than a year
1-3 years
3-5 years
5-10 years
10-20 years
20 years and over

7. Do you (or your family) own or rent the place where you live?

Own
Rent

8. Who is the main earner in your family?

Respondent
Other

IF RESPONDENT IS MAIN EARNER, ASK A.

IF RESPONDENT IS NOT MAIN EARNER, ASK A AND B.

- A. What kind of work does the main earner do?

Job: _____

Industry: _____

9. How much training did you receive in preparation for this job?

Job: _____

Agency: _____

How long have you worked as a counselor?

10. Would you tell me in which one of these general groups your own total yearly family income falls--before taxes? We need this information just to make sure we are getting a good sample.

- A. Under \$500
- B. \$500 up to \$1,000
- C. \$1,000 up to \$2,000
- D. \$2,000 up to \$3,000
- E. \$3,000 up to \$4,000
- F. \$4,000 up to \$5,000
- G. \$5,000 up to \$7,500
- H. \$7,500 up to \$10,000
- I. \$10,000 and over
- Refused

11. Sex of respondent:

Male
Female

12. Race of Respondent:

White
Non-white

13. Time of interview:

Before 12 noon
12 noon to 6 p.m.
After 6 p.m.

14. Location of interview:

Home
Other (SPECIFY)

15. INTERVIEWERS RATINGS:

A. Did you feel that the respondent was cooperative?

Very cooperative
Rather cooperative
Rather uncooperative
Very uncooperative
Can't say

- B. Did you feel that the respondent was being frank and honest in his statements?

Completely frank and honest
Usually frank and honest
Frequently not frank and honest
Usually not frank and honest
Can't say

- C. Did you feel that the respondent was at all disturbed or bothered by the content of the interview?

Very disturbed
Rather disturbed
Slightly disturbed
Not disturbed
Can't say

16. Place and State:

17. Date of Interview:

18. Interviewer's Signature:

A P P E N D I X B

VIGNETTES

1. I'm thinking of a man--let's call him Frank Jones--who is very suspicious; he doesn't trust anyone, and he's sure that everybody is against him. Sometimes he thinks that people he sees on the street are talking about him or following him around. A couple of times, now, he has beaten up men who didn't even know him. The other night, he began to curse his wife terribly; then he hit her and threatened to kill her because, he said, she was working against him like everyone else.
2. Now here's a young woman in her twenties, let's call her Betty Smith--she has never had a job, and she doesn't seem to want to go out to look for one. She is a very quiet girl, she doesn't talk much to anyone, even her own family, and she acts like she is afraid of people, especially young men her own age. She won't go out with anyone, and whenever someone comes to visit her family, she stays in her room till they leave. She stays by herself and daydreams all the time, and shows no interest in anything or anybody.
3. Here's another kind of man; we can call him George Brown. He has a good job and is doing pretty well at it. Most of the time he gets along all right with people, but he is always touchy and he always loses his temper quickly, if things aren't going his way, or if people find fault with him. He worries a lot about things, and he seems to be moody and unhappy all the time. Everything is going all right for him, but he can't sleep nights, brooding about the past, and worrying about the things that might go wrong.
4. How about Bill Williams? He never seems to be able to hold a job very long, because he drinks so much. Whenever he has money in his pocket, he goes on a spree; he stays out to all hours drinking, and never seems to care about his wife or children. Sometimes he feels very bad about the way he treats his family; he begs his wife to forgive him and promises to stop drinking, but he always goes off again.
5. Here's a different sort of girl--let's call her Mary White. She seems happy and cheerful; she's pretty, has a good job and is engaged to marry a nice young man. She has loads of friends; everybody likes her,

and she's always busy and active. However, she just can't leave the house without going back to see whether she left the gas stove lit or not. And she always goes back again just to make sure she locked the door. And one other thing about her; she's afraid to ride up and down in elevators; she just won't go any place where she'd have to ride in an elevator to get there.

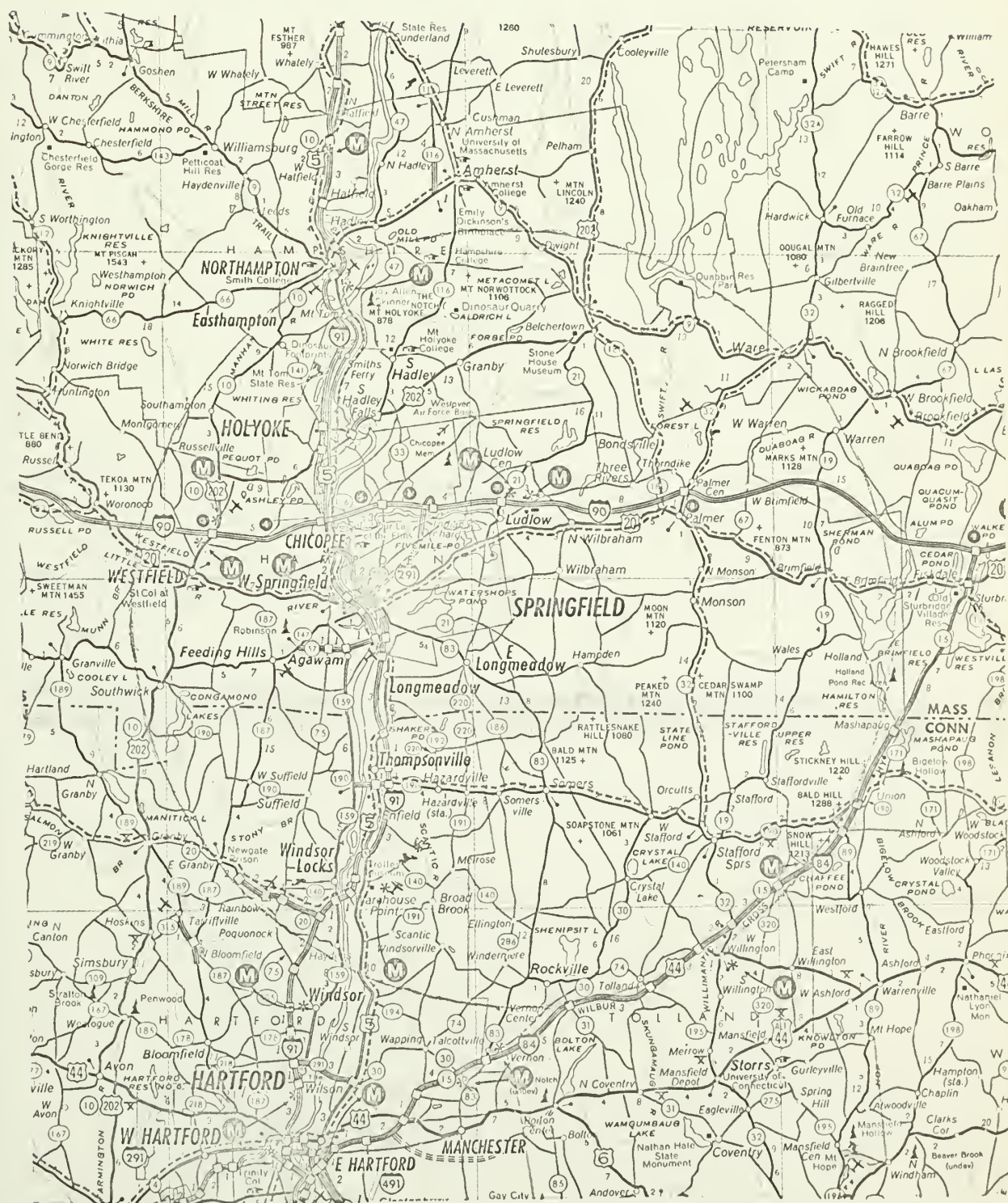
A P P E N D I X C

SOCIAL DISTANCE SCALE (AGREE-DISAGREE)

1. We should strongly discourage our children from marrying anyone who has been mentally ill.
Agree_____Disagree_____
2. I can imagine myself falling in love with a person who had been mentally ill.
Agree_____Disagree_____
3. I would be willing to room with a former mental hospital patient.
Agree_____Disagree_____
4. If I were resident owner of an apartment house, I would hesitate to rent living quarters to a former mental hospital patient.
Agree_____Disagree_____
5. If I were employed at a job, I wouldn't hesitate to share my office with someone who had been mentally ill.
Agree_____Disagree_____
6. If I owned an empty lot beside my house, I would be willing to sell it to a former mental patient.
Agree_____Disagree_____
7. I wouldn't work for anyone who had been mentally ill.
Agree_____Disagree_____
8. I would be willing to sponsor a person who had been mentally ill for membership in my favorite club or society.
Agree_____Disagree_____

APPENDIX D

GEOGRAPHIC AREA FROM WHICH RESPONDENTS WERE SAMPLED



A P P E N D I X E

AGENCIES REPRESENTED BY THE PARAPROFESSIONALS
AND THE PROFESSIONALS CHOSEN
FOR THIS RESEARCH

Child and Family Service of Springfield, Inc.
367 Pine Street
Springfield, Massachusetts

Child Guidance Clinic of Springfield
759 Chestnut Street
Springfield, Massachusetts

Children's Protective Services of Massachusetts
Society for the Prevention of Cruelty to Children
1727 Northampton Street
Holyoke, Massachusetts

Children's Study Home
44 Sherman Street
Springfield, Massachusetts

Concentrated Employment Program
11 Eastern Avenue
Springfield, Massachusetts

Downey Side
1532 Bay Street
Springfield, Massachusetts

Hampden District Mental Health Clinic
759 Chestnut Street
Springfield, Massachusetts

Hill McKnight Neighborhood Councils, Inc.
Neighborhood Social Service Center
80 Hancock Street
Springfield, Massachusetts

Hilltop Childrens Service
820 State Street
Springfield, Massachusetts

Marathon House
5 Madison Avenue
Springfield, Massachusetts

Monson State Hospital
Palmer, Massachusetts

Northampton State Hospital
Northampton, Massachusetts

Northampton Veterans Administration Hospital
Northampton, Massachusetts

Our Lady of Lourdes School
280 Tinkham Road
Springfield, Massachusetts

Our Lady of Providence Home for Children
2112 Riverdale Road
West Springfield, Massachusetts

Social and Psychological Services Unit
Springfield Public Schools
118 Alden Street
Springfield, Massachusetts

Springfield Hospital Medical Center
Psychiatric Unit
759 Chestnut Street
Springfield, Massachusetts

Wesson Women's Hospital
735 Chestnut Street
Springfield, Massachusetts

A P P E N D I X F

ANALYSIS OF RESPONSES BY INDIVIDUAL PROFESSIONAL RESPONDENTS TO THE CASE DESCRIPTIONS IN STAR'S VIGNETTES

Respondent	Something wrong	Nothing wrong	Don't know	Has not	Has	Don't know	Serious	Not serious	Depends	Don't know
1	5	0	0	4	0	0	2	3	1	0
2	5	0	0	5	0	0	3	2	0	0
3	3	0	0	1	1	0	1	0	2	0
4	4	1	0	1	4	0	1	0	0	0
5	5	0	0	1	2	0	2	0	1	0
6	5	0	0	2	0	0	4	1	0	0
7	4	0	0	0	0	3	1	0	0	0
8	4	0	0	0	5	0	0	0	0	1
9	5	0	0	3	0	1	1	0	0	0
10	4	1	0	4	0	0	2	1	1	0
11										
12	5	0	0	5	0	0	2	0	3	0
13	4	0	5	0	0	0	0	0	0	0
14	5	0	1	0	2	1	1	0	1	0
15	5	0	0	1	3	0	2	0	0	0
16	5	0	0	0	2	0	2	0	0	0
17	5	0	0	1	2	0	2	0	1	0
18	5	0	0	2	0	1	1	1	2	0
19	5	0	0	5	0	0	0	3	2	0
20	5	0	0	1	1	0	0	0	4	0

A P P E N D I X G

ANALYSIS OF RESPONSES BY INDIVIDUAL PARAPROFESSIONAL RESPONDENTS TO
THE CASE DESCRIPTIONS IN STAR'S VIGNETTES

Respondent	Something wrong	Nothing wrong	Don't know	Has not	Has not	Don't know	Serious	Not serious	Depends	Don't know
21	5	0	0	4	0	1	0	3	2	0
22	5	0	0	1	1	1	2	1	1	0
23	5	0	0	4	0	1	0	4	0	1
24	5	0	0	5	0	0	0	4	0	1
25	3	2	0	1	1	1	0	2	0	0
26	5	0	0	3	0	2	0	1	2	0
27	5	0	0	2	2	0	1	2	0	0
28	4	1	0	3	0	1	0	3	0	1
29	5	0	0	0	5	0	0	0	0	0
30	5	0	0	2	1	2	0	1	3	0
31	5	0	0	3	0	1	1	2	0	2
32	5	0	0	3	0	1	0	2	1	1
33	4	0	1	1	3	1	0	0	2	0
34	5	0	0	3	1	1	0	3	0	0
35	5	0	0	3	0	1	1	3	1	0
36	3	1	1	3	0	1	0	4	0	0
37	3	0	2	0	3	2	0	0	0	0
38	5	0	0	5	0	0	0	0	0	0
39	5	0	0	4	1	0	1	2	1	0
40	3	0	2	1	0	2	2	0	0	3

A P P E N D I X H

ANALYSIS OF RATINGS OF RESPONSES OF PROFESSIONALS TO THE QUESTIONS: "What do you think makes him act this way?" and "Can they get over these nervous conditions by themselves or do they need help to get over them?"

Re-spond-ent	"P" Ratings ^a		"R" Ratings ^b		"P-R" Ratings ^c		N.A. ^d or Don't know
	Rater-1	Rater-2	Rater-1	Rater-2	Rater-1	Rater-2	
1	5	3	0	2	1	1	0
2	6	5	0	0	0	1	0
3	6	5	0	1	0	0	0
4	5	5	0	0	0	0	1
5	3	6	0	0	1	0	1
6	5	5	0	0	0	0	1
7	2	1	1	1	0	1	3
8	5	5	0	0	0	0	1
9	6	6	0	0	0	1	0
10	5	4	1	1	0	0	0
11	5	5	1	1	0	0	0
12	5	4	0	1	1	1	0
13	1	1	0	0	0	0	5
14	6	6	0	0	0	0	0
15	6	5	0	0	0	0	0
16	6	6	0	0	0	0	0
17	5	5	0	0	0	0	1
18	6	6	0	0	0	0	0
19	6	5	0	0	0	1	0
20	4	4	1	1	0	0	1

^a"P"=Psychiatric.

^b"R"=Normative-Rational.

^c"P-R"=Both Psychiatric and Normative-Rational.

^dN.A.=No Answer.

A P P E N D I X I

ANALYSIS OF RATINGS OF RESPONSES OF PARAPROFESSIONALS TO THE QUESTIONS: "What do you think makes him act this way?" and "Can they get over these nervous conditions by themselves or do they need help to get over them?"

Re- spond- ent	"P" Ratings ^a		"R" Ratings ^b		"P-R" Ratings ^c		N.A. ^d or Don't know
	Rater-1	Rater-2	Rater-1	Rater-2	Rater-1	Rater-2	
21	4	5	1	1	1	0	0
22	2	4	4	2	0	0	0
23	4	4	0	0	0	0	2
24	4	5	1	0	0	0	1
25	4	4	1	1	1	1	0
26	2	3	2	2	1	0	1
27	3	4	1	0	1	1	1
28	3	4	2	0	1	2	0
29	4	5	0	0	1	0	1
30	0	4	4	1	1	0	1
31	2	4	4	2	0	0	0
32	4	4	0	0	1	1	1
33	0	2	6	4	0	0	0
34	4	4	1	1	1	1	0
35	4	4	1	1	1	1	0
36	2	3	2	2	2	1	0
37	4	4	1	1	0	0	1
38	5	4	0	1	1	1	0
39	3	4	2	1	1	1	0
40	2	1	1	2	0	0	3

^a"P"=Psychiatric.

^b"R"=Normative-Rational.

^c"P-R"=Both Psychiatric and Normative-Rational.

^dN.A.=No Answer.

A P P E N D I X J

NUMBER OF "AGREES" AND "DISAGREES" ON THE CUMMINGS SOCIAL
DISTANCE SCALE FOR EACH PROFESSIONAL RESPONDENT

Respondent	Agree	Disagree
1	5	3
2	5	3
3	5	3
4	5	3
5	6	2
6	5	3
7	5	3
8	4	4
9	5	3
10	4	4
11	5	3
12	6	2
13	5	3
14	5	3
15	4	4
16	4	4
17	6	2
18	6	2
19	5	3
20	5	3

A P P E N D I X K

NUMBER OF "AGREES" AND "DISAGREES" ON THE CUMMINGS SOCIAL
DISTANCE SCALE FOR EACH PARAPROFESSIONAL RESPONDENT

Respondent	Agree	Disagree
21	6	2
22	5	3
23	5	3
24	5	3
25	5	3
26	4	4
27	5	3
28	5	3
29	5	3
30	6	2
31	5	3
32	4	4
33	5	3
34	5	3
35	5	3
36	5	3
37	3	5
38	6	2
39	4	4
40	5	3

A P P E N D I X L

PERCENTAGE OF RESPONDENTS IN SEVEN STUDIES LABELING
CASE ABSTRACTS AS INDICATING MENTAL ILLNESS

Type of Case ^a	Rural			Profes- sionals ^h		
	National Study 1950 ^b (N=3500)	Canadian Study 1955 ^c (N=540)	Baltimore Study 1960 ^d (N=1736)	Urban Leaders 1962 ^e (N=80)	North Carolina ^f 1968 (N=1405)	Para- profes- sionals ^h 1971 (N=20)
Paranoid	75	69	91	100	--	80
Simple						
Schizo- phrenic	34	36	78	72	76	70
Alcoholic	29	25	62	63	69	55
Depressed						
Neurotic	18	20	--	50	56	25
Compulsive						
Phobic	7	4	--	40	--	20

^aCase abstracts developed by Shirley Star (NORC Survey). Not all abstracts were used in each study.

^bStar.

^cCumming and Cumming.

^dLemkau and Crocetti.

^eDohrenwend, Bernard and Kolb.

^fBentz, Edgerton and Kherlopian.

^gBentz, Edgerton and Miller.

^hHirsch.

A P P E N D I X M

DEFINITIONS OF MENTAL ILLNESS TAKEN FROM THE
DIAGNOSTIC AND STATISTICAL MANUAL
OF MENTAL DISORDERS OF THE
AMERICAN PSYCHIATRIC
ASSOCIATION

Psychosis

Patients are described as psychotic when their mental functioning is sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life. The impairment may result from a serious distortion in their capacity to recognize reality. Hallucinations and delusions, for example, may distort their perceptions. Alterations of mood may be so profound that the patient's capacity to respond appropriately is grossly impaired. Deficits in perception, language and memory may be so severe that the patient's capacity for mental grasp of his situation is effectively lost.

295.0 Schizophrenia, simple type. This psychosis is characterized chiefly by a slow and insidious reduction of external attachments and interests and by apathy and indifference leading to impoverishment of interpersonal relations, mental deterioration, and adjustment on a lower level of functioning. In general, the condition is less dramatically psychotic than are the hebephrenic, catatonic, and paranoid types of schizophrenia. Also, in contrast with schizoid personality in which there is little or no progression of the disorder.

297.0 Paranoia. This extremely rare condition is characterized by gradual development of an intricate, complex, and elaborate paranoid system based on and often proceeding logically from misinterpretation of an actual

event. Frequently the patient considers himself endowed with unique and superior ability. In spite of a chronic course the condition does not seem to interfere with the rest of the patient's thinking and personality.

301.0 Personality Disorders. This group of disorders is characterized by deeply ingrained maladaptive patterns of behavior that are perceptibly different in quality from psychotic and neurotic symptoms. Generally, these are life-long patterns often recognizable by the time of adolescence or earlier.

301.1 Paranoid Personality. This behavioral pattern is characterized by hypersensitivity, rigidity, unwarranted suspicion, jealousy, envy, excessive self-importance, and a tendency to blame others and ascribe evil motives to them. These characteristics often interfere with the patient's ability to maintain satisfactory interpersonal relations. Of course, the presence of suspicion alone does not justify this diagnosis, since the suspicion may be warranted in some instances.

Neuroses

The neuroses, as contrasted to the psychoses, manifest neither gross distortion or misinterpretation of external reality, nor gross personality disorganization. A possible exception to this is the hysterical neurosis, which some believe may occasionally be accompanied by hallucinations and other symptoms encountered in psychoses.

Traditionally, neurotic patients, however severely handicapped by their symptoms, are not classified as psychotic because they are aware that their mental functioning is disturbed.

300.0 Neuroses. Anxiety is the chief characteristic of the neuroses. It may be felt and expressed directly, or it may be controlled unconsciously and automatically by conversion, displacement, and various other psychological mechanisms. Generally, these mechanisms produce symptoms

experienced as subjective distress from which the patient desires relief.

300.2 Phobic Neuroses. This condition is characterized by intense fear of an object or situation which the patient consciously recognizes as no real danger to him. His apprehension may be experienced as faintness, fatigue, palpitations, perspiration, nausea, tremor, and even panic. Phobias are generally attributed to fears displaced to the phobic object or situation from some other object of which the patient is unaware. A wide range of phobias have been described.

300.3 Obsessive Compulsive Neuroses. This disorder is characterized by the persistent intrusion of unwanted thoughts, urges, or actions that the patient is unable to stop. The thoughts may consist of single words or ideas, ruminations, or trains of thought often perceived by the patient as nonsensical. The actions vary from simple movements to complex rituals such as repeated handwashing. Anxiety and distress are often present either if the patient is prevented from completing his compulsive ritual or if he is concerned about being able to control it himself.

300.4 Depressive Neurosis. This disorder is manifested by an excessive reaction of depression due to an internal conflict or to an identifiable event such as the loss of a love object or cherished possession.

303.0 Alcoholism. This category is for patients whose alcoholic intake is great enough to damage their physical health, or their personal or social functioning, or when it has become a prerequisite to normal functioning. If the alcoholism is because of another mental disorder, both diagnoses should be made.

